

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01540

CERTIFICATE OF DEATH

01537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 33 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HARVEY	Middle E.	Lost 4. DATE OF DEATH ABE Month FEB. Day 19, Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
13. FATHER'S NAME JOHN ABE		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA-LEVELS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and electrolyte imbalance INTERVAL BETWEEN ONSET AND DEATH 1992 2 Weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Carcinoma of prostate and colon, with bony and pulmonary metastases 2 years stating the underlying cause (c) Diabetes mellitus, very mild			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20o. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 17th, 1966 , to Feb. 19, 1967 , that (I) (we) last saw the deceased alive on Feb. 19, 1967 , and that death occurred at 10:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Wyand F. Doerner Jr. M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED 2-22-67		22d. ADDRESS 414 N. MECHANIC ST., CUMBERLAND, MD.	
23o. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 22, 1967	23c. NAME OF CEMETERY OR CREMATORIUM ABE CEMETERY
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25o. REC'D BY REGISTRAR WILEY FORD, WEST, VIRGINIA
		DATE FEB 27 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Scarpelli</i>

6676

DATE 10-10-72

RECORDED

BY [unclear]

IN [unclear]

ON [unclear]

AT [unclear]

IN [unclear]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01541

CERTIFICATE OF DEATH

01538

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 Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #6, Cumberland		d. STREET ADDRESS McMullen Highway		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Samuel		First	Middle Singleton	Lost	4. DATE OF DEATH Feb. 10 1967	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/29/94	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Buffalo Mills, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Silas Adams				14. MOTHER'S MAIDEN NAME Cora Suter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 161-12-6641		17. INFORMANT Mrs. Maude Adams, Cumberland, Md. RD6		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 5810 DUE TO Cessation of Liver & jaundice INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO Residuals of left knee & pelvis left								
stating the underlying cause (c) DUE TO 17-11 Seizure - psychosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from NOV. 21, 1966 , to Feb. 10, 1967 , that (I) (we) last saw the deceased alive on Feb. 9 1967 , and that death occurred at 6:30 AM , from causes and on the date stated above.								
22a. SIGNATURE <i>L. B. Mathews, M.D.</i>		22b. DATE SIGNED 2/16/67						
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Dry Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Manns Choice, Pa. RD#1		
24. FUNERAL DIRECTOR <i>Howard S. Ziegler</i>		ADDRESS Hyndman, Pa.		25a. REC'D. BY REGISTRAR FEB 16 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20 M 1/66								

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10 RELEASE UNDER E.O. 14176

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. If pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01542

01539

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN lb

5 Minutes

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Miners Hospital

3. NAME OF
DECEASED
(Type or print)

JOHN

Middle

ANDERSON

Last

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

10/29/1905

9. AGE (In years
last birthday)

61

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Celanese Employee

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Anderson

14. MOTHER'S MAIDEN NAME

Minerva Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. ETHEL ANDERSON, Lonaconing, MD.
(WIFE)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary Occlusion

Coronary Thrombosis

Coronary Sclerosis

INTERVAL BETWEEN
ONSET AND DEATH

Minutes

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20a. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER February 8, 1967

Address (Street, city, town, or county)
Cumberland, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Burial 2/10/1967

Memorial Park
ADDRESS

Frostburg, MD.

23. FUNERAL DIRECTOR

George Eichhorn

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
FEB 9 1967 Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01543

CERTIFICATE OF DEATH

01540

1. PLACE OF DEATH a. COUNTY ALLEGANY CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	d. STREET ADDRESS 313 MARYLAND AVENUE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAY	Middle ALLEN	4. DATE OF DEATH Month FEB Day 17 Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN H BATES, JR		14. MOTHER'S MAIDEN NAME JOYCE REED GOODMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ***	16. SOCIAL SECURITY NO. -----	17. INFORMANT MEMORIAL HOSPITAL	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral DUE TO 7635 INTERVAL BETWEEN ONSET AND DEATH Today Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (6 mo gestation) DUE TO 3 days (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Infantile type Coarctation of aorta, Hyeline Membrane.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 12 , 19 67 to Feb 17 , 19 67 , that (I) (we) last saw the deceased alive on Feb 17 , 19 67 , and that death occurred at 6:50 PM from causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) R. A. REITER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/20/67
22d. ADDRESS 112 Bedford St 401 DECATUR ST. CUMBERLAND, MD.		23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 20, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.	25a. REC'D BY REGISTRAR CHARLES J. GUNN	25b. REGISTRAR'S SIGNATURE Charles J. Gunn	
20 M 1/66	20A 15 (4)	DATE FEb 23 1967	7-215453

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01544

CERTIFICATE OF DEATH

01541

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>maryland</i> b. COUNTY <i>Allegany</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>			c. LENGTH OF STAY IN 1b <i>Cumberland</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>402 Pulaski St.</i>			d. STREET ADDRESS <i>402 Pulaski St.</i>		
3. NAME OF DECEASED (Type or print)		First <i>Margaret</i>	Middle <i>A.</i>	Last <i>Blake</i>	4. DATE OF DEATH <i>Feb. 16 1967</i>
5. SEX		6. COLOR OR RACE <i>Female White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 28, 1876</i>	9. AGE (in years last birthday) IF UNDER 1 YEAR <i>90 yrs.</i> IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		
13. FATHER'S NAME <i>Augustine Burkey</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Corrionansville, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None.</i> 17. INFORMANT <i>Edward Blake</i> Address <i>Cumberland, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i> <i>Arteria</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Myocarditis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>10 yrs</i> <i>5 yrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20d. INJURY OCCURRED <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at work</i>	20f. (City or town) <i>None.</i> (County) <i>None.</i> (State) <i>None.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 14, 1967</i> to <i>Feb. 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb. 10, 1967</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Clayton Lomax</i> 22b. DATE SIGNED <i>2/17/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>1</i>			22d. ADDRESS <i>236 Va Sts Cumberland Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/20/67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Patrick's Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Md. Judge Md</i>	
24. FUNERAL DIRECTOR <i>Lam Stein Inc. Cumb. Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>EEB 20 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE					

18110

18110

John Kennedy - 18110 - 18110

John Kennedy - 18110 - 18110

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01545

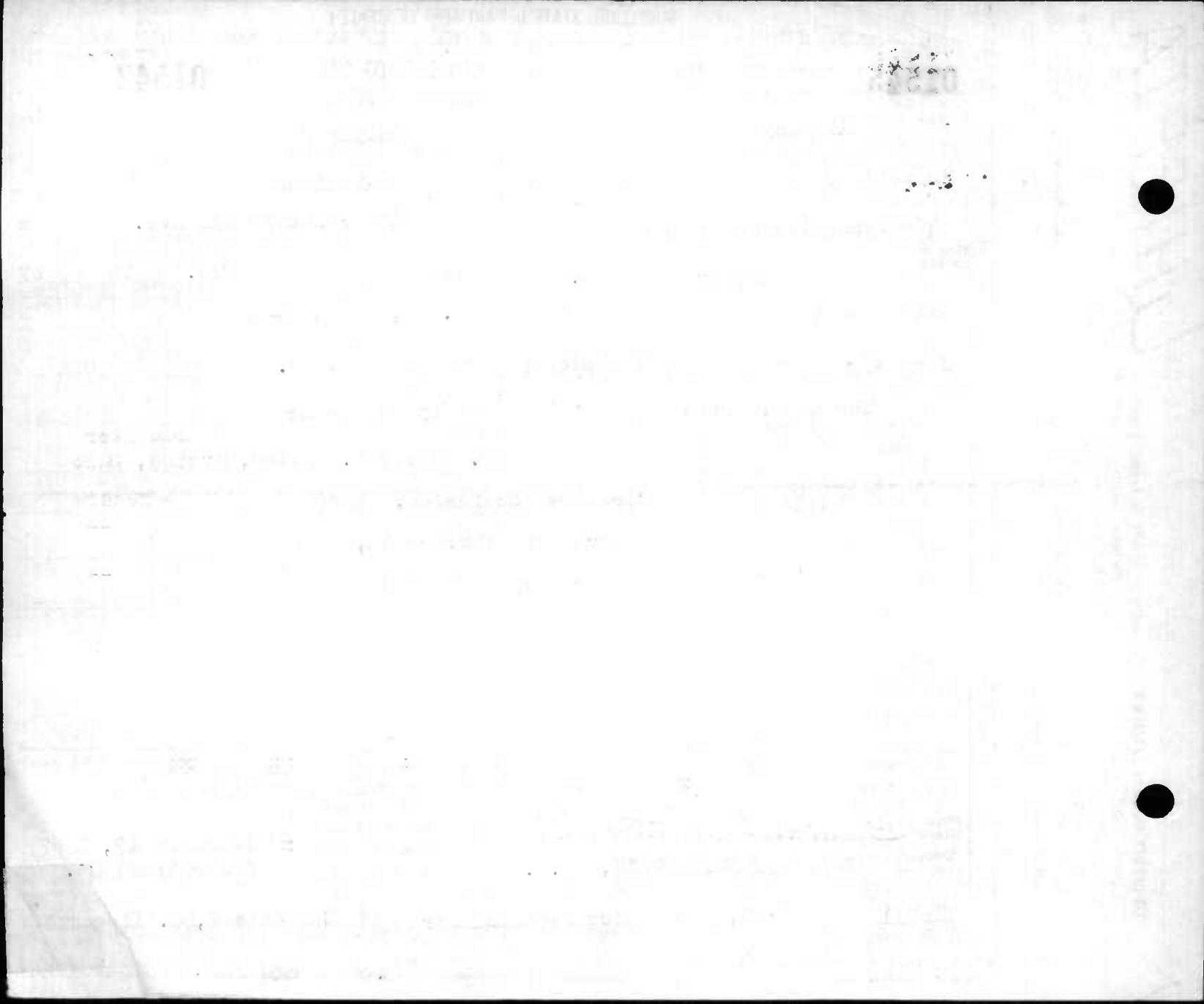
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01542

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, above Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 69 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 404 Pennsylvania Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert B. Brant		First	Middle
4. DATE OF DEATH Feb. 19 1967	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1898 Nov. 28, 1898		9. AGE (In years (last birthday) 88-68 yrs.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Brant		14. MOTHER'S MAIDEN NAME Daisy Valentine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Robert M. Tabler, Ravenna, Ohio	
17. INFORMANT Daughter		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4/201</i>		Coronary Occlusion, Left Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) due to (c)		Coronary Thrombosis, Left --	
		Coronary Sclerosis --	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1967	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) Zion Memorial Park	
24. FUNERAL DIRECTOR <i>James F. Scagelli - Cumberland, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 23 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Gray</i>



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH					01543					
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY							
ALLEGANY MARYLAND			MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 Weeks							
CUMBERLAND			d. STREET ADDRESS							
SACRED HEART HOSPITAL.			R.T. # 1 BOX 582							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
ELVA C. BROTEMARKLE						FEB.	21	19	67	
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
FEMALE WHITE			WIDOWED	□	DIVORCED	10-22-00	66 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Retired Clergyman						LUKE, MD.			U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Rhoda Shoemaker				
Lloyd Weller						Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
No			216-22-6144			PT'S CHART			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inevitable shock</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i> DUE TO (c)	
									INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			2dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19										
21. I certify that (I) (this hospital) attended the deceased from <i>2/21</i> , 19 <i>67</i> , to <i>2/21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/21</i> , 19 <i>67</i> , and that death occurred at <i>5:15 PM</i> , from the causes and on the date stated above.										
22a. SIGNATURE <i>DR. Pagan</i>										
22c. PHYSICIAN'S NAME (Type) DR. PAGAN, M.D.			22b. DATE SIGNED <i>2/22/67</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/24/67			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION (City, town or county) (State) Cumberland Allegany Md	
24. FUNERAL DIRECTOR			ADDRESS H. Lee Silcox Cumberland Maryland 21502			25a. REC'D BY REGISTRAR FEB 23 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
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U.S. DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01547

CERTIFICATE OF DEATH

01544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Allegheny</i> <i>Cumberland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>WV</i> b. COUNTY <i>Monroe</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Keyser</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital, Cumberland, Md.</i>		d. STREET ADDRESS <i>115-W Piedmont St.</i>	
e. NAME OF DECEASED (Type or print) <i>Anna</i>		4. DATE OF DEATH Month <i>February</i> Day <i>19</i> Year <i>1967</i>	
5. SEX <i>Female</i> COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4-18-3875</i>		9. AGE (In years last birthday) <i>91</i> yrs. IF UNDER 1 YEAR Months <i>10</i> Days <i>11</i> Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Elk Park, MD</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard G. Burk</i>		14. MOTHER'S MAIDEN NAME <i>Mary M. Whetzel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-18-2944</i>	
17. INFORMANT <i>Mrs Arvel Jeffery, Cumberland, MD</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary sclerosis</i> DUE TO last (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute bronchitis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter date or injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Elk Garden</i> (County) <i>Elk Garden</i> (State) <i>WV</i>	
21. I certify that (I) <i>this hospital</i> attended the deceased from <i>2-18-1967</i> to <i>2-19-1967</i> , that (I) <i>late</i> last saw the deceased alive on <i>2-18-1967</i> , and that death occurred at <i>Elk Garden</i> M, from causes and on the date stated above.		22b. DATE SIGNED <i>2-19-1967</i>	
22c. SIGNATURE <i>Howard L. Tolson MD</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Howard L. Tolson</i>		22d. ADDRESS <i>Elk Garden, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-22-67</i>	
23c. NAME OF CEMETERY OR Crematory <i>Matthew Hill</i>		23d. LOCATION (City or Town) <i>Elk Garden</i> (County) <i>Elk Garden</i> (State) <i>WV</i>	
24. FUNERAL DIRECTOR <i>Thomas J. Smith Jr., Keyser</i>		25a. REC'D BY REGISTRAR <i>DATE FEB 21 1967</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles J. Moore</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01548

CERTIFICATE OF DEATH

01545

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6/29/1955	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Catherine	Middle J. Corrigan	4. DATE OF DEATH February 16, 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/9/1869
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 97 yrs.
13. FATHER'S NAME Matthew Corrigan		14. MOTHER'S MAIDEN NAME Ann Garvy	11. BIRTHPLACE (County & State, or foreign country) Corriganville, Md.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ① Niegrovitis ob. degenerans inc. Semic Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. ② Coarcto Vasculor Renal Disease (b) ③ Astro Sclerotic general & cerebral. (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/29/1955 , to 2/16/1967 , that (I) (we) last saw the deceased alive on 2/15/1967 , and that death occurred at A. M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Matthews Jr.</i>		22b. DATE SIGNED 2/16/1967	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cem.
24. FUNERAL DIRECTOR Laura Stein Inc. Cumb. Md.		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
ADDRESS		25a. REC'D BY REGISTRAR FEB 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
01549				01546													
<p>1. PLACE OF DEATH a. COUNTY Allegany MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland</p> <p>c. LENGTH OF STAY IN lb 1 Year</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 32½ West 1st Street</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Allegany</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland</p> <p>d. STREET ADDRESS 32½ W. 1st St.</p>													
<p>3. NAME OF DECEASED (Type or print) First Middle Last George S. Cox</p>				<p>4. DATE OF DEATH February 8, 1967</p>													
<p>5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 25, 1897</p>				<p>9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 69 yrs. 9 13 0 0</p>													
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Detective</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (County & State, or foreign country) Atlanta, Georgia</p>				<p>12. CITIZEN OF WHAT COUNTRY? USA</p>					
<p>13. FATHER'S NAME George W. Cox</p>				<p>14. MOTHER'S MAIDEN NAME Florence Perry</p>				<p>Address 32½ W. 1st. St.</p>				<p>INTERVAL BETWEEN ONSET AND DEATH 2 yrs</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes W.W. #1</p>				<p>16. SOCIAL SECURITY NO. 265-01-7388</p>				<p>17. INFORMANT Mrs Inez Bohrer Cox, Cumberland, Md.</p>				<p>18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]</p>					
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO</p>				<p>Conditions, if any, which gave rise to immediate cause (b) DUE TO</p>				<p>Acute Coronary Thrombosis Dura</p>				<p>caused by Arteriosclerosis</p>					
<p>caused by Arteriosclerosis</p>				<p>(c) DUE TO</p>													
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>												<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>													
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town)</p>		<p>(County)</p>		<p>(State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from Oct. 15 1966 to Feb. 8, 1967, that (I) (we) last saw the deceased alive on Dec. 10 1966, and that death occurred at 4:15 A.M. from the causes and on the date stated above.</p>												<p>22b. DATE SIGNED 2/11/67</p>					
<p>22a. SIGNATURE Clay E. Durrett M.D.</p>				<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>				<p>22d. ADDRESS 236 Va. Ave.</p>				<p>Cumberland, Maryland</p>					
<p>22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, MD</p>				<p>23d. LOCATION (City, town or county) (State) Paw Paw, West Virginia</p>													
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2/10/1967 Woodrow Cem.</p>				<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS W. Va.</p>				<p>23d. LOCATION (City, town or county) (State) Paw Paw, West Virginia</p>									
<p>24. FUNERAL DIRECTOR'S SIGNATURE Johnson Funeral Homes, Berkeley Spgs.</p>				<p>25a. REC'D BY REGISTRAR DATE FEB 14 1967</p>				<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.M
01550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01547

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 62 years						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		e. STREET ADDRESS 456 Baltimore Ave.						
3. NAME OF DECEASED (Type or print) Leroy		First Franklin	Middle Crawford					
4. DATE OF DEATH Feb. 3 1967		Month Feb.	Day 3					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Crawford		14. MOTHER'S MAIDEN NAME Mary Albright						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. War I		17. INFORMANT Mrs. Helen Mc Kinley, Cumberland, Md.		Address Sister		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure					INTERVAL BETWEEN ONSET AND DEATH Hours	
		DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Myxoma of Left Auricle					---	
		DUE TO (b) (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.							ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli, Cumberland, Md.</i>		

211610

211610

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01551

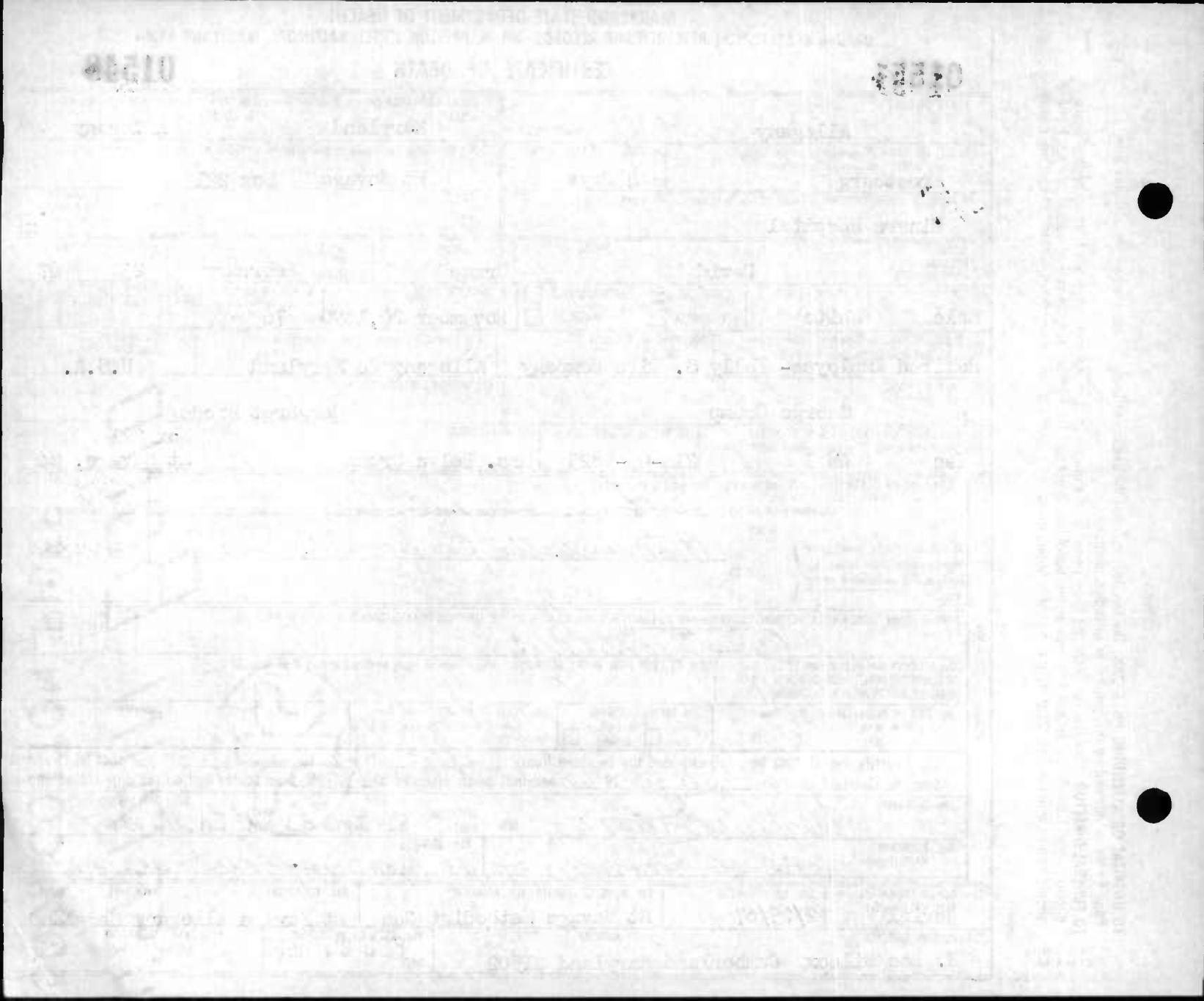
CERTIFICATE OF DEATH

01548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Savage		d. STREET ADDRESS Box 221			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David		First	Middle	Last	4. DATE OF DEATH February 23	Month	Day	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH November 20, 1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee- Kelly S. Tire Company		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Co Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Crump				14. MOTHER'S MAIDEN NAME Margaret Brode					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-05-9823		17. INFORMANT Mrs. Belva Crump		Address Box 221 Mt Savage, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) Arteriosclerotic Cardiovascular Disease 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH 11 hrs -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) X							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. X 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/18 , 19 67 , to 2/23 , 19 67 , that (I) (we) last saw the deceased alive on 2/23 19 67 , and that death occurred at 1:45 AM , from causes and on the date stated above.									
22a. SIGNATURE Martin M. Rothstein		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/24/67			
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN		22d. ADDRESS MD 48 BROADWAY - FROSTBURG - MD 21532							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/67		23c. NAME OF CEMETERY OR CREMATORIAL Mt Savage Methodist Cem		23d. LOCATION (City or Town) (County) (State) Mt Savage Allegany Maryland			
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland Maryland 21502		25a. REC'D. BY REGISTRAR FEB 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

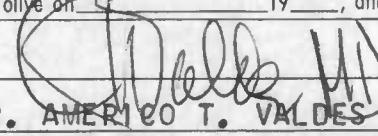
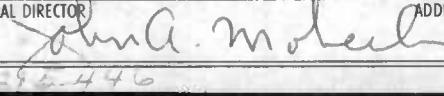
CERTIFICATE OF DEATH

01549

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01552

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby Boy A	Middle CURRENCE	4. DATE OF DEATH Month FEBRUARY Day 7 Year 19 67
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) 2 HRS.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME WILLIAM W. CURRENCE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ROBINETTE, JANET M.		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 776X DUE TO Thrombocytopenia months		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO Hemostatic (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 2nd Twin Fetal			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CUMBERLAND, MD.
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 196:40 P.M. , 19____, thot (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stoted above.	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-8-67
22c. PHYSICIAN'S NAME (Type) DR. AMERICO T. VALDES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL / CREMATION REMOVAL (Specify) CREMATION		23b. DATE THEREOF 02-10-67	23c. NAME OF CEMETERY OR CREMATORIALy Hospital
24. FUNERAL DIRECTOR 		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 15 1967
			25b. REGISTRAR'S SIGNATURE 

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MEG10

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Y1457 1A

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Y1457 1B 13030001

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Y1457 1C 13030001

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01553

CERTIFICATE OF DEATH

01550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 18 W. First Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Inez		First Inez	Middle Last Dawson
4. DATE OF DEATH Feb. 20 1967	Month Doy Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/72
9. AGE (In years last birthday) 94	10. IF UNDER 1 YEAR Months 94	11. IF UNDER 24 HRS. DAYS 94	12. IF UNDER 24 HRS. Hours 94
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (County & State, or foreign country) Grafton, W. Va.	
13. FATHER'S NAME A. H. (Art) Kelly		14. MOTHER'S MAIDEN NAME Susan Keister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address Granddaughter Mrs. Nina Straser, New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ⑥ Degenerative tho. degeneration Socia 1/23/1 DUE TO ② Arterio sclerosis general & cerebral			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ③ Headaches "lately strokes" DUE TO ④ 17/11 Severe psychosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV. 25 1966 to Feb. 20, 1967 , that (I) (we) last saw the deceased alive on Feb. 19 1967 , and that death occurred at 1 AM , from causes and on the date stated above.			
22a. SIGNATURE L. B. Mathews, M.D.		22b. DATE SIGNED M.D. ATTENDING MED. STAFF PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 22, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Rockwood Cemetery	23d. LOCATION (City or Town) (County) (State) Rockwood, Pa.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR FEB 23 1967
			25b. REGISTRAR'S SIGNATURE Charles J. Scarpelli

08210

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01554

CERTIFICATE OF DEATH

01551

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1109 VIRGINIA AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle L.	4. DATE OF DEATH Month FEBRUARY 20 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. AGE (In years less birthday) 78 yrs.		10. B. DATE OF BIRTH 8-25-1888	11. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Municipal	11. BIRTHPLACE (County & State, or foreign country) MARYLAND - CUMBERLAND
13. FATHER'S NAME JOSEPH DEATELHAUSER		14. MOTHER'S MAIDEN NAME JENNIE VALENTINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service)) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address MEMORIAL HOSPITAL, MEMORIAL AVE.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X <i>Arteritis</i>		INTERVAL BETWEEN ONSET AND DEATH Weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) Arteriosclerosis <i>Arteriosclerosis</i>		DUE TO Arteriosclerosis <i>Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Nat While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 2/17 1967 , that (I) (we) last saw the deceased alive on 2/19 1967 , and that death occurred at M , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Aleneen</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 2/20/67
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Park
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS	
		25b. REC'D BY REGISTRAR DATE FEB 24 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01555

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Res. Inst. before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kyle Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First William	Middle Oscar
Last Droege		4. DATE OF DEATH Feb. 4 1967	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1886
9. AGE (In years & months) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME OSCAR Droege		14. MOTHER'S MAIDEN NAME Rosa Rust	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705 05 5282	17. INFORMANT Otto Droege
		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia			
INTERVAL BETWEEN ONSET AND DEATH			
11201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Certane sclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lonaconing, Md.
20f. (City or town) Cumberland, Md.		(County) Maryland	
(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from Jan 30 1967 , to 2-4 1967 , that (I) (we) last saw the deceased alive on Jan 30 1967 , and that death occurred at Lonaconing, Md. , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 2-6-67	
M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. Leslie R. Miles		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Leslie R. Miles		22d. ADDRESS Lonaconing, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/67	23c. NAME OF CEMETERY OR CREMATORIALy Oakland, Cem.
23d. LOCATION (City or Town) Oakland		(County) Garrett	
(State) Md.			
24. FUNERAL DIRECTOR John Bral		ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE FEB 9 1967
		25b. REGISTRAR'S SIGNATURE Charles Judy	

SCC10

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1 *M* **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #6385 2/17/67 PC

01556

CERTIFICATE OF DEATH

01553

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CUMBERLAND MEMORIAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) KATHLEEN		First	Middle	Last	4. DATE OF DEATH DYE FEBRUARY 5 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 1-24-1917	9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.	
13. FATHER'S NAME ELLIS JAMES DYE			14. MOTHER'S MAIDEN NAME ELLA FOUTZ		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMB. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Multiple Pulmonary Metastases INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Carcinoma of breast (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Feb 17 (County) Feb 17 (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 17 to Feb 17 , that (I) (we) last saw the deceased alive on Jan 17 , and that death occurred at 2:50 AM M, from causes and on the date stated above.					
22a. SIGNATURE <i>Al Weisman</i>					
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE THEREOF 2/8/67	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill	23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.	
24. FUNERAL DIRECTOR S. P. Boral			ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE FEB 10 1967	25b. REGISTRAR'S SIGNATURE <i>Al Weisman</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01557

CERTIFICATE OF DEATH

01554

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole rural		c. LENGTH OF STAY IN 1b 10 Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole -rural		d. STREET ADDRESS R.D. 1 Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 1 Westernport		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Clark Fisher		First Kenneth	Middle Clark
Last Fisher		4. DATE OF DEATH Feb. 21	Month Feb. Day 21 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH April 24, 1914
10a. USUAL OCCUPATION (Give kind of work done during most recent year, even if retired) Research		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	9. AGE (In years last birthday) 52 yrs.
13. FATHER'S NAME Edwin Fisher		11. BIRTHPLACE (County & State, or foreign country) Allegany, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-0421	17. INFORMANT Madeline Fisher-R.D. 1, Westernport, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { Emphysema last. (b) DUE TO ASCVD (c) DUE TO		<i>myocardial infarction</i> 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthrosis, Emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westernport, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19, to 2-21-67 , 19, that (I) (we) last saw the deceased alive on 2-20-67 , 19, and that death occurred at 720 M, from causes and on the date stated above.			
22o. SIGNATURE William W. Lesh		22b. DATE SIGNED 2-21-67	
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Westernport, Md.	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		23d. LOCATION (City or Town) (County) (State) Westernport	
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Peters
24. FUNERAL DIRECTOR J.W. Boal		ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR Charles Jagger
			25b. REGISTRAR'S SIGNATURE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any time is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
01558				01555											
<p>1. PLACE OF DEATH a. COUNTY ALLEGANY</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p> <p>c. LENGTH OF STAY IN 1b LIFE</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</p> <p>a. STATE MARYLAND</p> <p>b. COUNTY ALLEGANY</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p> <p>d. STREET ADDRESS ROUTE 2</p>											
<p>3. NAME OF DECEASED (Type or print) ROBERT</p> <p>First ROBERT</p> <p>Middle NEEL</p>				<p>Last FLORA</p> <p>4. DATE OF DEATH FEB. 17 1967</p>				<p>Month FEB.</p> <p>Day 17</p> <p>Year 1967</p>							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 4, 1917		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL ROOM WORKER</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY TIRE INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>				<p>12. CITIZEN OF WHAT COUNTRY? USA</p>			
<p>13. FATHER'S NAME ELLIS FLORA</p>				<p>14. MOTHER'S MAIDEN NAME EDITH FLORA</p>											
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) YES WW 2</p>				<p>16. SOCIAL SECURITY NO. 214 07 4927</p>				<p>17. INFORMANT MARGARET FLORA, ROUTE 2, CUMBERLAND, MD.</p>				<p>Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)</p>				<p>CEREBRAL HEMORRHAGE</p>				<p>INTERVAL BETWEEN ONSET AND DEATH 4 days</p>							
				<p>HYPERTENSIVE CARDIOVASCULAR DISEASE</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>												<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p>									
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Benedict Skitarelic</i></p> <p>EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.</p>												<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>			
												<p>DATE SIGNED 2/18/67</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>				<p>22b. DATE THEREOF FEB. 20, 1967</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL ZION MEMORIAL PARK</p>		<p>22d. LOCATION (City, town, or county) CUMBERLAND, MD.</p>				<p>(State)</p>			
<p>23. FUNERAL DIRECTOR BYRON KIGHT</p>				<p>ADDRESS CUMBERLAND, MD.</p>				<p>24a. REC'D BY REGISTRAR FEB 21 1967</p>				<p>24b. REGISTRAR'S SIGNATURE <i>Charles J. Indee</i></p>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01559

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 239 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIRGINIA ELIZABETH FORBECK		4. DATE OF DEATH FEBRUARY 11 1967	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-22-1899		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Women's Apparel	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB BURNS		14. MOTHER'S MAIDEN NAME MARY GABER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 172-07-9386D	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Priming DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause _____ last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) CUMBERLAND (County) ALLEGANY (State) MARYLAND			
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19 to 2-11 , 1967, that (I) (we) last saw the deceased alive on 2-11 1962 , and that death occurred at 5:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>William W. James</i>		22b. DATE SIGNED 2/14/67	
22c. PHYSICIAN'S NAME (Type) DR. W. W. JAMES		22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/67	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.	25a. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01560		CERTIFICATE OF DEATH				01557				
1. PLACE OF DEATH O. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATE Maryland b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7/16/63	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			d. STREET ADDRESS 312 Spruce St. Westernport, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Florence		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8/17 / 1883	9. AGE (In years last birthday) 85 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Mr. George Ternent			14. MOTHER'S MAIDEN NAME Mary Crowe			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599 Cumb., Md. Allegany County Infirmary Records			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Myocarditis, old degenerative, 443A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2. Arterio Sclerosis & Hypotension DUE TO (b) 3. Old Syphilitic nephritis DUE TO (c) 4. old Cholecystitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 7/16/1963			20f. (City or town) 2/14/1967 (County) 19 (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			21. I certify that (I) (this hospital) attended the deceased from 7/16/1963 , 19, to 2/14/1967 19, that (I) (we) last saw the deceased alive on 2/14/1967 19, and that death occurred at P. M., from causes and on the date stated above.			22. SIGNATURE Lee B. Mathews, M.D. 2:00 P.M.			22b. DATE SIGNED 2/15/1967	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M.D.			22d. ADDRESS 49 Greene St. Cumb., Maryland			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/17/67	
24. FUNERAL DIRECTOR E. Boal			23c. NAME OF CEMETERY OR CREMATORIAL PHilos Cem.			23d. LOCATION (City or Town) WESTERNPORT		(County) MD. (State)		
ADDRESS Westernport, Md.			25a. RECD BY REGISTRAR FEB 17			25b. REGISTRAR'S SIGNATURE J Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01561

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be rejoined by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EUGENE Middle KERMIT Last FURLOW		4. DATE OF DEATH FEBRUARY 12 1967	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1908
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMOBILE MECHANIC		10b. KIND OF INDUSTRY LIGHT & DECKER	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
13. FATHER'S NAME FURLOW, THOMAS		14. MOTHER'S MAIDEN NAME ELIZABETH HULL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-01-7895	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Carcinomatosis - Colon, lung</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 2/11 1967 and that death occurred at 3:25 P.M. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE DR. THOMAS F. LUSBY		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/13/67
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		22d. ADDRESS 932 NATIONAL HIGHWAY, LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/67	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01562

CERTIFICATE OF DEATH

01559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg (Rural)		c. LENGTH OF STAY IN 1b 7 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg (Rural)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose EDITH	First	Middle	Lost GARLITZ
4. DATE OF DEATH Feb. 10 1967	Month	Doy	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 15, 1880		9. AGE (In years lost birthday) 86 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Finzel, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Urias McKenzie	
14. MOTHER'S MAIDEN NAME Cordellia Hutzell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. — — —		17. INFORMANT Thomas McKenzie, R.D. Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerosis Cardiovacular Disease		INTERVAL BETWEEN DNSET AND DEATH 25 yrs.	
4221 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ (c) _____		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 X		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	
20f. (City or town) X		(County) X	
(State) X			
21. I certify that (I) (this hospital) attended the deceased from 2 Feb. 1967 , to 10 Feb. 1967 , that (I) (we) last saw the deceased alive on 10 Feb. 1967 , and that death occurred at 2:40 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 2/12/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.		22d. ADDRESS 48 BROADWAY - FROSTBURG - MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL St. Michaels Cem.		23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR John Newman		ADDRESS Grantsville, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
DATE FEB 14 1967			

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01563

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01560

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 LaVALE MONTHS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JOHN'S LANE		d. STREET ADDRESS 414 OLDTOWN ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAGDALENA	Middle MINNIE	Last GREEN
4. DATE OF DEATH Month Day Year	FEBRUARY 19, 1967	5. SEX FEMALE	6. COLOR OR RACE WHITE
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 24, 1882	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN REUSCHEL	14. MOTHER'S MAIDEN NAME ANNA BRITTON HARTUNG	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	Address
16. SOCIAL SECURITY NO. 220-34-1625	17. INFORMANT WM. J. CREGAN, JOHN'S LANE, LaVALE, MD.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>cardio-pneu-vascular disease</i> <i>osteosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH 1 year 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-2-</u> , 19 <u>60</u> , to <u>2-19-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-18-</u> 19 <u>67</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.	22a. SIGNATURE <i>L. Brings</i>	22b. DATE SIGNED <u>2-20-67</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) L. Brings	22d. ADDRESS 57 Greene St., Cumberland, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL TRINITY LUTHERAN CEMETERY	23d. LOCATION (City, town or county) (State) CUMBERLAND, ALLEGANY, MD.
24. FUNERAL DIRECTOR JOHN J. HAFFER, JR.	ADDRESS 330 BALTO. AVE., CUMB., MD.	25a. REC'D BY REGISTRAR DATE FEB 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Hafer</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01561

01564

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) with CUMBERLAND nearest town)		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 17 GLEN VIEW TERRACE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle D.	Last HEACOX
4. DATE OF DEATH	Month FEBRUARY	Day 7	Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-01
9. AGE (In years at birthday) 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Salesman	11. BIRTHPLACE (County & State, or foreign country) AL TOONA, PA.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME HEACOX, ROBERT	14. MOTHER'S MAIDEN NAME DICK, JEANETTA	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWI	
16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 90 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Valley Md	20f. (City or town) Cumberland (County) Md (State) MD
21. I certify that (I) (this hospital) attended the deceased from 3/5/67 , 19 8:40 P.M. , 19 19 , that (I) (we) last saw the deceased alive on 3/7/67 , 19 19 , and that death occurred at M. from causes and on the date stated above.			
22a. SIGNATURE <i>Richard Williams</i>	22b. DATE SIGNED 2/15/67		
22c. PHYSICIAN'S NAME (Type) DR. RICHARD WILLIAMS	22d. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/10/67	23c. NAME OF CEMETERY OR CREMATORIAL Potomac Mem. Ph.	23d. LOCATION (City or Town) (County) (State) Cumberland Md
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb Md	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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01565

CERTIFICATE OF DEATH

01562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 1 HR. 20 MIN.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 353 BALTIMORE AVE.	
3. NAME OF DECEASED (Type or print)	First MINNIE Middle O	Last HICKLE	4. DATE OF DEATH Month FEBRUARY Day 18 Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME JOHN W. JONES		14. MOTHER'S MAIDEN NAME MARY E. (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 05 8522	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) DUE TO Acute cerebral vascular disease hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from Sept. 1967 to Oct. 1967, that (I) (we) last saw the deceased alive on 21/8/67 1967, and that death occurred at 10:30 P.M. front causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 3/19/67	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT CUMBERLAND, MD.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 22, 1967	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK
24. FUNERAL DIRECTOR BYRON KIGHT		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
		25a. REC'D BY REGISTRAR FEB 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01566

CERTIFICATE OF DEATH

01563

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 78 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 227 ARCH ST.	
3. NAME OF DECEASED (Type or print) First LUCY Middle ANN Last HUMBERTSON		4. DATE OF DEATH FEB. 7 1967	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) W.V. 1861		12. CITIZEN OF WHAT COUNTRY? U.S.A. Cleveland Ohio	
13. FATHER'S NAME AD SIRBAUGH -ALVEY SIRBAUGH		14. MOTHER'S MAIDEN NAME SARAH LEDWICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO <i>Uraemia</i> INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>R. Central Nervous System</i> 2 mos			
stating the underlying cause (c) DUE TO <i>Left Hemiplegia</i> 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1, 1966</i> to <i>Feb. 7, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb. 7, 1967</i> , and that death occurred at <i>1:05 AM</i> , from causes and on the date stated above.			
22o. SIGNATURE <i>Clayton, Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>2/18/67</i>
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS 236 VA. AVENUE, CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1967	
23c. NAME OF CEMETERY OR CREMATORIALy Davis Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 10 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01567

01561

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Corriganville		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS 011	
3. NAME OF DECEASED (Type or print) Walter		First J.	Middle Jensen
4. DATE OF DEATH February	Month 3,	Day 1967	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1890
9. AGE (In years last birthday) 78 (76 yr.)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O Shops	11. KIND OF BUSINESS OR INDUSTRY Railroading	12. BIRTHPLACE (State or foreign country) Denmark Coleman, Wis. USA
13. FATHER'S NAME unkn	14. MOTHER'S MAIDEN NAME unkn	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1914-1928 Navy	
16. SOCIAL SECURITY NO. 705-05-4750		17. INFORMANT Harry Stegmaier, Cumberland, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 11201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		Coronary occlusion	
DUE TO } } DUE TO (c)		Coronary sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hyndman	(County) Pennsylvania	(State) Pennsylvania	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1967	
22c. NAME OF CEMETERY OR CREMATORIUM Hyndman Cemetery		22d. LOCATION (City, town, or county) Hyndman, Pennsylvania	
23. FUNERAL DIRECTOR Harvey L. Feigles		ADDRESS Hyndman, Pennsylvania	
24a. REC'D BY REGISTRAR FEB 9		24b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME 5M 1/63		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01568

CERTIFICATE OF DEATH

01565

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PA. b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 44 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN, PA. RT. 1 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GUY	Middle F	Last KENNELL
4. DATE OF DEATH Month FEB	Month 20	Doy 19	Year 67
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9-19-89
9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) PENNA.	
13. FATHER'S NAME WILLIAM B. KENNELL	14. MOTHER'S MAIDEN NAME EFFIE LEPLEY	15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 220-34-1285	17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Shizenceous INTERVAL BETWEEN ONSET AND DEATH 45 days			
33.2X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) Generalized Arterioclerosis stating the underlying cause (c)			
DUE TO last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) CUMBERLAND (County) Bedford Co. (State) Pa.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19, to 1-20 , 19 67 , that (I) (we) last saw the deceased alive on 1-20 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE William P. James		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/21/67
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 23, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hyndman Cemetery	23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.
24. FUNERAL DIRECTOR Alvarez H. Ziegler	25a. REC'D BY REGISTRAR DATE FEB 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01566

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb LIFE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 37 MEMORIAL AVE.			d. STREET ADDRESS 37 MEMORIAL AVE.				
3. NAME OF DECEASED (Type or print) IRA H. KING			First	Middle	Lost		
4. DATE OF DEATH FEB. 13 1967	Month	Doy	Year				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED XX NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 26, 1897	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET WORKER			10b. KIND OF BUSINESS OR INDUSTRY CITY GOV'T	11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME CALVIN I. KING			14. MOTHER'S MAIDEN NAME CORA F. PERDEW				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217 10 6418		17. INFORMANT MRS. LOLA E. KING		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
CORONARY OCCLUSION							
CORONARY SCLEROSIS						--	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO XX	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND, MD.	(County) MD.	(State) MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> BENEDICT SKITARELIC M.D.	
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						22. DATE SIGNED FEB. 13, 1967	
ACTUAL SIGNATURE BENEDICT SKITARELIC		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		RT. 9, CUMBERLAND, MD. (Mailing Address)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 15, 1967		23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE FEB 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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01570

CERTIFICATE OF DEATH

01567

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING	c. LENGTH OF STAY IN lb 2 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	d. STREET ADDRESS 65 EAST MAIN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KYLE NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle JACOB	Last KUNKLE	
4. DATE OF DEATH FEBRUARY 28, 1967	Month Day Year	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JANUARY 21, 1880	9. AGE (In years last birthday) yrs. 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLASS WORKER	10b. KIND OF BUSINESS OR INDUSTRY GLASS	11. BIRTHPLACE (County & State, or foreign country) MONACA, PENNA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADAM KUNKLE	14. MOTHER'S MAIDEN NAME JOANNE TUNGET			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 217-16-4532	17. INFORMANT MRS. JOHN A. WINEBRENNER, 144 WASHINGTON	STREET, FROSTBURG, MD	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Disease (b) Arteriosclerosis DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Semile Psychosis				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1967 , to Feb. 28, 1967 , that (I) (we) last saw the deceased alive on Feb. 23, 1967 , and that death occurred at MD , from causes and on the date stated above.				
22a. SIGNATURE <i>Leslie R. Miles, M.D.</i>	ATTENDING M.D. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3-2-67
22c. PHYSICIAN'S NAME (Type) LESLIE R. MILES, M.D.	22d. ADDRESS STATE ST., LONACONING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEM.	23d. LOCATION (City or Town) FROSTBURG,	(County) (State) MARYLAND
24. FUNERAL DIRECTOR MARILOU M. SOWERS HAFER-SOWERS FUNERAL HOME	ADDRESS 60W. MAIN, FROSTBURG	25a. REC'D BY REGISTRAR MAR 7 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH						01568					
1. PLACE OF DEATH a. COUNTY ALLEGANY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL									b. COUNTY ALLEGANY		
3. NAME OF DECEASED (Type or print) CARRIE			First R.	Middle L.	Last CANTER	4. DATE OF DEATH FEBRUARY 2 1967			Month	Day	Year
5. SEX FEMALE			6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3-29-75	9. AGE (In years last birthday) 91 yrs.			10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home.			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JESSIE ROBINSON			14. MOTHER'S MAIDEN NAME ELMIRA (WILHELM) (D)			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			PT'S CHART		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) congestive heart failure (c) coronary sclerosis arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 week								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury In Part I or Part II of Item 18.)			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
21. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 67 , to 2-2 , 19 67 that (I) (we) last saw the deceased alive on 2-2-1967 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE h. Brings						22b. DATE SIGNED 2-3-67					
22c. PHYSICIAN'S NAME (Type) DR. L BRINGS, MD.			22d. ADDRESS 57 GREENE ST. CUMBERLAND, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2-5-67			23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL			23d. LOCATION (City, town or county) (State) FROSTBURG, ALLEG. MD.		
24. FUNERAL DIRECTOR Joseph R. Quest Jr. Frostburg, MD			ADDRESS Charles Judge			25a. REC'D BY REGISTRAR DATE FEB 8 1967			25b. REGISTRAR'S SIGNATURE		
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01572

CERTIFICATE OF DEATH

01569

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.		PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb 1/23/1967		
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3.		NAME OF DECEASED (Type or print)	First Anna	Middle Elizabeth	Last Lapp	4. DATE OF DEATH February 1, 1967	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4/12/1874	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Shirt, Pajama Factory		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Andrew A. Lapp		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Wagner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-9643			17. INFORMANT P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Neoplastic, ch. degenerativa 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ② Arterio sclerosis, general + cerebral } DUE TO (b) ③ Ch. neoplatis c. crooked & deca-					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/23/67 , 19, to 2/1/67 , 19, that (I) (we) last saw the deceased alive on 2/1/67 , 19, and that death occurred at P. M. , fram causes and an the date stated above. at 12:00 P.M.							
22a. SIGNATURE <i>Lee B. Mathews</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 2/2/1967		
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 4, 1967		23c. NAME OF CEMETERY OR CREMATORIUM FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		ADDRESS HAFER FUNERAL HOME 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR FEB 9 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01573

CERTIFICATE OF DEATH

01570

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 FROSTBURG		c. LENGTH OF STAY IN lb D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 28 BEALL'S LANE	
3. NAME OF DECEASED (Type or print) SALOME		First SALOME	Middle Lost LA RUE
4. DATE OF DEATH FEBRUARY		Month 12,	Doy Year 19 67
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH DEC. 1, 1891		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done at work, not at home or part-time)		10b. KIND OF BUSINESS OR INDUSTRY PAJAMA FACTORY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME WASHINGTON WARNER		14. MOTHER'S MAIDEN NAME NANCY ENGLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-14-4530	17. INFORMANT Address PAUL LA RUE, FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 4201			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Artery Disease ½ hr.			
stating the underlying cause (c) Arteriosclerotic Heart Disease 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-8 - 1966 , to 2-12 - 1967 , that (I) (we) last saw the deceased alive on 2-11 - 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE A. Paige Strong		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 2/13/67
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS 167 E. Main St - FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 15 '67	23c. NAME OF CEMETERY OR CREMATORIUM GREENVILLE CEMETERY
23d. LOCATION (City or Town) POCOHONTAS, PA.		(County) (State)	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 16 1967
			25b. REGISTRAR'S SIGNATURE J Charles Judge

07210

67210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01574

CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 3 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Hammond				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Dennis	Middle Lashbaugh	Last	4. DATE OF DEATH Feb. 1 1967	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14, 1895	9. AGE (In years last birthday) 71 yrs.	10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (County & State, or foreign country) Allegany-Maryland	
13. FATHER'S NAME Jacob Lashbaugh		14. MOTHER'S MAIDEN NAME Laura V. Preston		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-01-3756		17. INFORMANT Address Isabelle Lashbaugh-Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Coronary occlusion 4201				INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) Coronary sclerosis (c) Arteriosclerosis (general)		1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Westernport, Md.	
21. I certify that (I) (this hospital) attended the deceased from April 1963 , to 1 Feb 1967 , that (I) (we) last saw the deceased alive on 27 Jan 1967 , and that death occurred at 9:30 p.m. from the causes and on the date stated above.				22b. DATE SIGNED	
22a. SIGNATURE Norman Reeves		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Norman Reeves, M.D.		22d. ADDRESS Westernport, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/67		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View	
24. FUNERAL DIRECTOR E. Boal		ADDRESS Westernport, Md.		25a. REC'D. BY REGISTRAR DATE 1-0 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1960

1960

Robert F. Kennedy, Senator from New York

John F. Kennedy

(January 1, 1960)

1960

John F. Kennedy, Senator from New York

John F. Kennedy

John F. Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

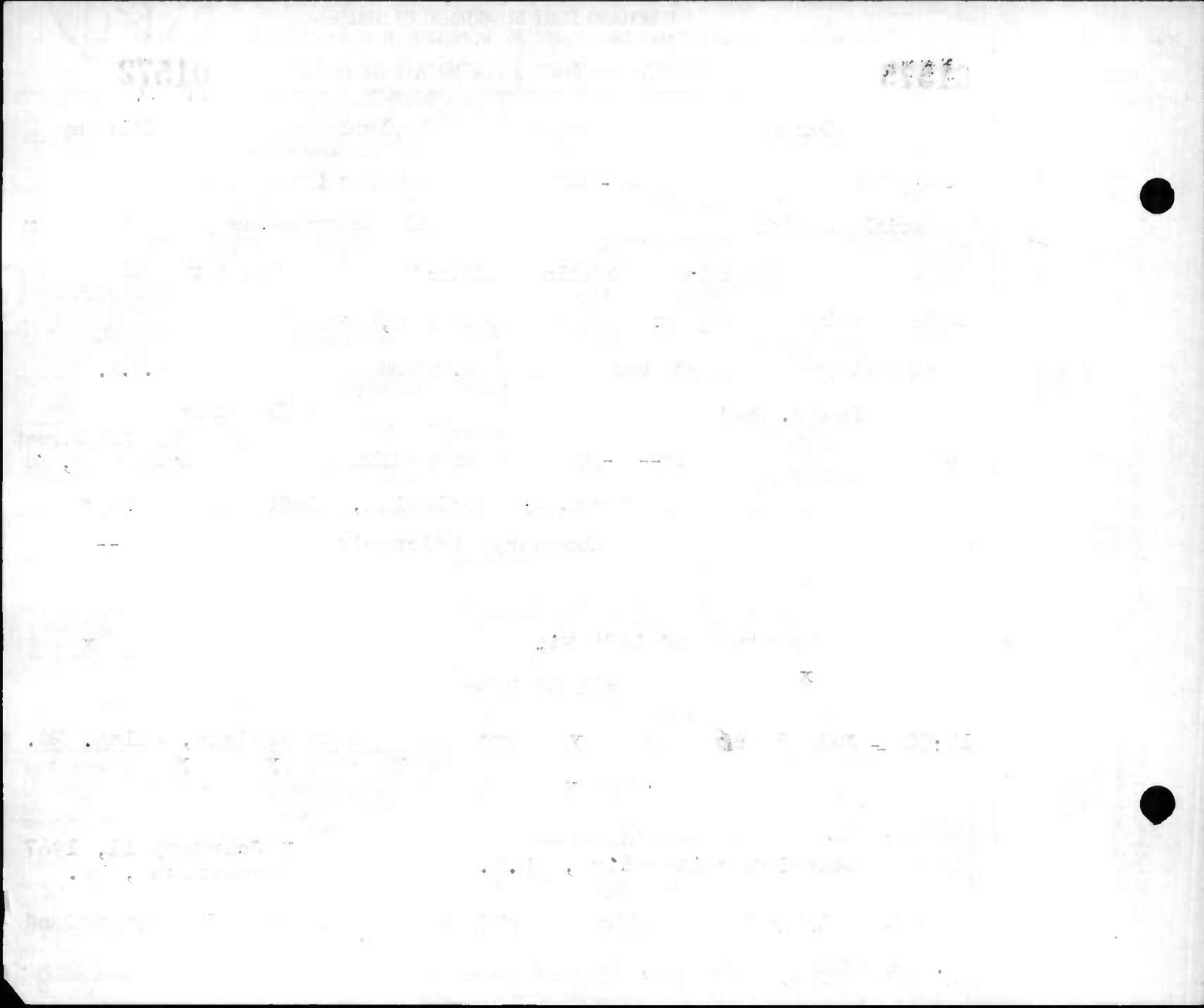
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01572

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 521 Shriver Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Virginia		First Estella	Middle Lillard	Lost	4. DATE OF DEATH February 11 1967	Month February	Day 11	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 22, 1900	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John H. Reed		14. MOTHER'S MAIDEN NAME Myrtle Krause						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-9466		17. INFORMANT Wm Harry Lillard		Address 445 Dirk Street Cumberland, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)		Coronary Occlusion, Left				INTERVAL BETWEEN ONSET AND DEATH Days		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4201</i>		DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) (c)		Coronary Sclerosis		--		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Fracture of left Hip						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 10:00 a.m. July 25, 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Benedict Skitarelic</i> M.D.		22. DATE SIGNED February 11, 1967		
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/67		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01576

CERTIFICATE OF DEATH

01573

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb R.F.D.#3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BEDFORD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORA ALMA LITTLE		First	Middle
4. DATE OF DEATH FEB. 12 1967		Month	Day Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH DEC.10, 1883		9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
11. BIRTHPLACE (County & State, or foreign country) TWIGG TOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL S. TWIGG		14. MOTHER'S MAIDEN NAME JENNIE "MIDDLETON" TWIGG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-7961D	17. INFORMANT R.F.D. ^{Address} #73 BEDFORD ROAD MRS KATHRYN TEWELL CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		Chronic Congestive Heart Failure 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		OUE TO Myocardial Infarctions, old and recent 1 week	
		DUE TO Hypertensive and Arteriosclerotic CVB (latest)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 10, 1960 , to Feb 12th, 1967 , that (I) (we) last saw the deceased alive on Feb. 12th 1967 , and that death occurred at 3 p.M. from causes and on the date stated above.		22b. DATE SIGNED Feb. 13, 1967	
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER, JR.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 414 N. MECHANIC ST. CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 15 Feb. 1967	23c. NAME OF CEMETERY OR CREMATORIUM HILLCREST BURIAL PARK
24. FUNERAL DIRECTOR H. LEE SILCOX		ADDRESS 404 DECATUR STREET CUMBERLAND, MARYLAND	25a. REC'D BY REGISTRAR DATE FEB 15 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01577

CERTIFICATE OF DEATH

01574

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 11 DAYS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 3, BEDFORD, PA.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			e. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) ELSIE		First M.	Middle LLEWELLYN	4. DATE OF DEATH FEB. 23 1967	Month Day Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-90	9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MD.	
13. FATHER'S NAME WILLIAM MATTHEWS			14. MOTHER'S MAIDEN NAME ANNIE LOWERY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 205-30-5904		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5021 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to Acute Myocardial Infarction due to Chronic Bronchitis, Heart Failure.					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Cerebral Hemorrhage					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1965	
20f. (City or town) CUMBERLAND		(County) MARYLAND		(State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19, to 2/23/67 , 1967, that (I) (we) last saw the deceased alive on 2/23/67 and that death occurred at 10:00 AM , from causes and on the date stated above.					
22a. SIGNATURE H. Lee Silcox					
22b. DATE SIGNED 2/24/67					
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/67		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
23d. LOCATION (City or Town) Cumberland Allegany Maryland		(County) MARYLAND		(State) MD.	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502			ADDRESS		
25a. REC'D BY REGISTRAR Clarendon Judge			25b. REGISTRAR'S SIGNATURE		
DATE FEB 28 1967					

15610

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YOUNG

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YOUNG

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01578

CERTIFICATE OF DEATH

01575

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
11. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.	
12. MEDICAL CERTIFICATION	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital	
52	
3. NAME OF DECEASED First Middle Last	
(Type or print) Mary Agnes Maguire	
4. DATE OF DEATH Month Day Year	
2 14 1967	
5. SEX	
Female White	
6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH	
11-1-95	
9. AGE (in years last birthday)	
71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Housewife	
10b. KIND OF BUSINESS OR INDUSTRY	
Own Home	
11. BIRTHPLACE (County & State, or foreign country)	
Little Orleans, Md.	
12. CITIZEN OF WHAT COUNTRY?	
USA	
13. FATHER'S NAME	
John Keifer	
14. MOTHER'S MAIDEN NAME	
Margaret Fahey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFIRMITY	
Address	
patient's chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myatheros</i>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterosclerosis Heart Disease</i>	
DUE TO Hyperension Heart Disease (c)	
INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Multiple Arteriosclerosis of the Aorta = Thoracic, abdominal; atherosclerosis of the peripheral arteries</i>	
10 yr	
10 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While factory, street, office bldg., etc.) p.m. at work at work	
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)	
19 57 to 2/14 1967	
21. I certify that (I) (this hospital) attended the deceased from , 1957, to , 1967, that (I) (we) last saw the deceased alive on 2/13 1967, and that death occurred at M, from the causes and on the date stated above.	
22a. SIGNATURE <i>H. Weisman</i>	
22b. DATE SIGNED 2/14/67	
22c. PHYSICIAN'S NAME (Type) SG WEISMAN MD	
22d. ADDRESS 54 GREENE ST CUMBERLAND MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Feb. 17, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	
23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR ADDRESS	
James F. Scarpelli, Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE	
DATE 52 17 1967 Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01579

CERTIFICATE OF DEATH

01576

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 600 SHRIVER AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First REBECCA	Middle 	Last MARX
4. DATE OF DEATH	Month FEBRUARY	Doy 22	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAROLD FINE		14. MOTHER'S MAIDEN NAME FLORENCE ROSENTHAL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 7 days 11201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Myocardial infarction, antero-septal 3 months. stating the underlying cause (c) A.S. Cardiovascular Disease 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Gen. arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 Dec. , 1966, to 22 Feb. , 1967, that (I) (we) last saw the deceased alive on 21 Feb. 1967, and that death occurred at 2:20 P.M. , from causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/67	
23c. NAME OF CEMETERY OR CREMATORIAL East View Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR Louis Stein, Inc.		ADDRESS	
		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE FEB 27 1967	

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FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01577

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale Md.		c. LENGTH OF STAY IN 1b 25yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 539 National Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lee B. Mathews		First	Middle
4. DATE OF DEATH February 20 1967	Last	Month	Day
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1891
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Doctor	
11. BIRTHPLACE (State or foreign country) Maysville Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Asbury		14. MOTHER'S MAIDEN NAME Carrie Rosa Porter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W.I.	
17. INFORMANT Mrs. Carrie Mathews		Address 539 National Hwy.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. White Not White p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work
20f. (City or town) CUMBERLAND		(County) MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> BENEDICT SKITARELIC ACTUAL SIGNATURE EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			
22. DATE SIGNED February 20, 1967		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 2/23/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	
24. FUNERAL DIRECTOR Louis Stein Inc. 117 Frederick St.		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John G. Young	

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INVESTIGATOR

DR.

VALERIE MELTON

23 SEPTEMBER 1982

23 SEPTEMBER 1982

SO 05 SEPTEMBER 1982

DR.

VALERIE MELTON

23 SEPTEMBER 1982

23 SEPTEMBER 1982

CARLIE BOESE PORTER

WILLIAM VUPPER

23 SEPTEMBER 1982

DR. DR.

CRIMINAL INVESTIGATION

CRIMINAL INVESTIGATION

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PENNSTATE SURVEYOR, INC.

COMMISSIONER OF PUBLIC WORKS

STATE

PHILADELPHIA, PA COMPENSATING

5/5/82

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G386 3/13/67 pc

01581

CERTIFICATE OF DEATH

01578

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6/8/1913	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Mavinick		4. DATE OF DEATH Month February Day 19 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> X	8. DATE OF BIRTH UNKNOWN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) UNKNOWN		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Home records			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Dyscalculia Ch. degeneration Sociale 4221 DUE TO Arteriosclerosis generalized cerebral Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. Bilateral leg are. pectoris (at Hr. 105)			
(c) Farm Rail Ruptured 1913.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/8/1913 , 19 67 , to 2/19/1967 , that (I) (we) last saw the deceased alive on 2/18/1967 , and that death occurred at A. M. , from causes and on the date stated above.			
22a. SIGNATURE L. B. Mathews, M. D.		at 8:25 A.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/20/1967
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ALLEGANY COUNTY CEMETERY
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. RECEIVED BY REGISTRAR FEB 27 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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Castile 1972

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01582**CERTIFICATE OF DEATH****01579**

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 146 Hanover Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First William	Middle Frederick	Last McCormick	4. DATE OF DEATH 2	Month 17	Day 1967	Year
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/06	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Cumberland, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Charles McCormick	14. MOTHER'S MAIDEN NAME Anna Pleasant	Address
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 220 17 6855	17. INFORMANT Patient's Chart	INTERVAL BETWEEN ONSET AND DEATH 1 day
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 day
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Heart Failure		
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchiectasis		
DUE TO (c)		20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Pulmonary Fibrosis Emphysema		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-11 , 1967, to 2-17 , 1967, that (I) (we) last saw the deceased alive on 2-16 1967, and that death occurred at 2a M, from the causes and on the date stated above.	
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22a. SIGNATURE <i>Ralph W. Ballin</i>	22b. DATE SIGNED 2-17-67
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22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.	22d. ADDRESS 62 Greene St. Cumberland, Md. 21502
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 20, 1967	23c. NAME OF CEMETERY OR CREMATORIUM GREENMOUNT CEMETERY	23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.
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24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR FEB 21 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's directress, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01580

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7/1/1960	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
3. NAME OF DECEASED, (Type or print) First Mary Middle McDonald		d. STREET ADDRESS 19 Washington Street	
3. SEX Female 6. COLOR OR RACE White		4. DATE OF DEATH Month February Day 6, Year 1967	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		8. DATE OF BIRTH 11/19/1875	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years 91 <small>last birthday</small> yrs.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McDonald		14. MOTHER'S MAIDEN NAME Alice Halfpenny	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-44-3306	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Hypertension, chronic degenerative - 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Arteriosclerosis, general - (c) ③ Cerebral apoplexy & rt hemiplegia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/1960, 19 to 2/6/1967, 19, that (I) (we) last saw the deceased alive on 2/4/1967, 19, and that death occurred at 7:50 A.M. from causes and on the date stated above.		(at 7:50 A.M.)	
22a. SIGNATURE Lee B. Mathews, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 2/6/1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 9, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL HAVER		23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS HAVER FUNERAL HOME ADDRESS		25a. REC'D BY REGISTRAR DATE FEB. 10, 1967	
Marilyn M. Sowers 60 W. MAIN, FROSTBURG		25b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01581

CERTIFICATE OF DEATH

01584									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 26 BOONE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 26 BOONE STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First HARRY	Middle E.	Last MICHAEL	4. DATE OF DEATH FEBRUARY 25 1967	Month Day Year			
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 3-27-1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Machinist		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM A. MICHAEL		14. MOTHER'S MAIDEN NAME ADA MEASE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Venous Occlusion</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriovenous Fistula Disease</i> DUE TO lost. (c)				INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1957, 19 to 1967, 19, that (I) (we) last saw the deceased alive on Feb 21, 1967, and that death occurred at 2:20 P.M. from causes and on the date stated above.									
22a. SIGNATURE <i>J. G. O. Himmelwright</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD		22b. DATE SIGNED 9/27/67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 28, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20 M 1/66		DATE							

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01585

CERTIFICATE OF DEATH

01582

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 9 CAMP GROUND RD.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First BERNICE	Middle VIRGINIA	Last NIES	4. DATE OF DEATH Month FEBRUARY	Day 16	Year 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-01	9. AGE (In years at birthday) 66	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME ISSAC LONG			14. MOTHER'S MAIDEN NAME HAWK, AUGUSTA							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-28-9763		17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascula Occlusion</i> 4221 DUE TO <i>Arteriole burst caused Vascula Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Year</i> stating the underlying cause lost. (c)										INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1960 , 3:15 P.M. 2/16 , 1967, that (I) (we) last saw the deceased alive on 2/16 1967, and that death occurred of M , from causes and on the date stated above.										22b. DATE SIGNED 2/19/67
22a. SIGNATURE <i>DR. G. OVERTON</i>										22b. DATE SIGNED 2/19/67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS DR. G. OVERTON HIMMELWRIGHT CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 19, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge				
				DATE FEB 24 1967						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01586

CERTIFICATE OF DEATH

01583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

5/12/1965

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

o. STATE Maryland

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

011

3. NAME OF
DECEASED
(Type or print)First
BessieMiddle
LeeLast
O'Baker4. DATE
OF
DEATH
February 6, 1967

5. SEX

Female

6. COLOR OR RACE
White7. MARRIED
WIDOWED NEVER MARRIED DIVORCED 8. DATE OF BIRTH
5/28/18809. AGE (In years
last birthday)
86 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life even if retired)

N.Caretaker

10b. KIND OF BUSINESS OR
INDUSTRY

Private Club

11. BIRTHPLACE (County & State, or foreign country)

Flintstone, Maryland

12. CITIZEN OF WHAT
COUNTRY

U. S. A.

13. FATHER'S NAME

John William Thompson

14. MOTHER'S MAIDEN NAME

Sara Elbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

235-32-7015

17. INFORMANT P.O. Box 599, Cumberland, Md.

Allegany County Infirmary records.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

422.1

DUE TO

① Neglectful, Cha. dependent Socio

② Altered Schiz., general & cerebral

(b)

DUE TO

③ Bi lateral Cerebral

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour o.m.

p.m.

19

20d. INJURY OCCURRED

While Not While at work off work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/12/1965, 19, to 2/6/1967, 19, that (I) (we) last saw the deceased alive on 2/6/1967, 19, and that death occurred at A.M. from causes and on the date stated above.

at 9:40 A.M.

22a. SIGNATURE

B. Mathews

22b. DATE SIGNED

2/6/1967

22c. PHYSICIAN'S
NAME (Type)

Lee B. Mathews, M. D.

22d. ADDRESS

49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City or Town) (County) (State)

Burial

2/19/67

St. Peter & Paul Cemetery

Cumberland

Allegany, Md.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

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“I am not fit to be your master.”

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Journal of Democracy

2025年，中国将建成世界最大的电动汽车市场。

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theoretical model

• Geography

• **Ways to handle your money**

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• See [FAQs](#) for more information.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

01587

CERTIFICATE OF DEATH

01584

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 23 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 506 Maryland Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 506 Maryland Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James Joseph Pamepinto		First	Middle	Last	4. DATE OF DEATH Feb.	Month	Doy	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Jan. 15, 1917	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Doys	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Digester Operator		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (County & State, or foreign country) Mineral-West Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Pamepinto			14. MOTHER'S MAIDEN NAME Virginia Caldronne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 217-05-0987		17. INFORMANT Gladys Pamepinto-Westernport, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac arrest</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u></u>								
INTERVAL BETWEEN ONSET AND DEATH <u>4201</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-21-</u> , 19 <u>67</u> , to <u></u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-19</u> 19 <u>67</u> , and that death occurred at <u>515 1/2 W. Main St.</u> , from causes and on the date stated above.								
220. SIGNATURE <u>Robert W. Bess, Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-21-67</u>		
22c. PHYSICIAN'S NAME (Type) Robert W. Bess, Jr.		22d. ADDRESS Piedmont, W. Va.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/67		23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City or Town) (County) (State) Westernport, Md.		
24. FUNERAL DIRECTOR <u>E. J. Bess</u>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE <u>Charles J. Bess</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01588

CERTIFICATE OF DEATH

01585

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA		b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 HOUR 13 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGS		d. STREET ADDRESS 7523	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LOLA	Middle V.	Last PECK	4. DATE OF DEATH FEB. 21 1967	Month	Doy	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1909	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own house		11. BIRTHPLACE (County & State, or foreign country) FORT HILL, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY LIVINGOOD				14. MOTHER'S MAIDEN NAME NELLIE GROVE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X		DUE TO <i>Hodgkin's Disease</i>				Since 1964	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-21-1967 to 2-21-1967 , that (I) (we) last saw the deceased alive on 2-21-1967 and that death occurred at 11:58 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>W. F. Williams</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-22-67	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-24-67		23c. NAME OF CEMETERY OR CREMATORIAL Maple Glen		23d. LOCATION (City or Town) (County) (State) Spring Somerset Co Pa	
24. FUNERAL DIRECTOR Don J Newman, Grantsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
				DATE MAR 1 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01589

CERTIFICATE OF DEATH

01586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	b. COUNTY Allegany
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kyle Nursing Home		d. STREET ADDRESS East Main Street	
3. NAME OF DECEASED (Type or print) MARY		First JANE	Middle PEEBLES
4. DATE OF DEATH 2/28/1967	Month Day Year 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/30/1878	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Lonaconing, MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Gunning		14. MOTHER'S MAIDEN NAME Margaret Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT ROBERT PEEBLES Lonaconing, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		(SON) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Senile Psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 , to Feb. 28, 1967 , that (I) (we) lost sow the deceased alive on Feb 23 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE 	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-28-67
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.	22d. ADDRESS LONACONING MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/3/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Lonaconing, MD.
24. FUNERAL DIRECTOR GEORGE EICHORN	ADDRESS Lonaconing, MD.	25a. REC'D BY REGISTRAR DATE MAR 2 1967	25b. REGISTRAR'S SIGNATURE

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REFERENCES

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01590

CERTIFICATE OF DEATH

01587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS East Main Street	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle A.	4. DATE OF DEATH Month Feb. Month 13 Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		9. DATE OF BIRTH 1/19/90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (Country & State, or foreign country) SHAF Allegany, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis A. Plummer		14. MOTHER'S MAIDEN NAME AMANDA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-03-8851	
17. INFORMANT MR. ALGIE PLUMMER, E. MAIN STREET		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Diabetes Mellitus & Coma 260X DUE TO ② cerebral apoplexy - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ③ Arteriosclerosis General DUE TO ④ cerebral -	
		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1967 , to Feb. 13, 1967 , that (I) (we) last saw the deceased alive on Feb. 12, 1967 , and that death occurred at 1A.M. , from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE L. B. Mathews, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 15, 1967	23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK
24. FUNERAL DIRECTOR MARILOU M. SOWERS		23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND	
VR A15 (4) 20 M 1/86		25a. REC'D BY REGISTRAR CHARLES JUDGE	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

01591

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01588

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3		4		5		6			
FOR STATE HEALTH DEPT.		01591		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		01588							
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 40 Yrs.				b. COUNTY Allegany					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 328 Fayette				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Pansy				First Porter		Middle Porter		Last Feb.		4. DATE OF DEATH Feb. 28 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1883		9. AGE (In years last birthday) 83 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lawson Montgomery				14. MOTHER'S MAIDEN NAME Lousia Kight				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Leafy Matthews-Westernport, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)				Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH Sudden					
Coronary Sclerosis													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Westernport		(County) Cumberland		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
CHIEF MEDICAL EXAMINER <input type="checkbox"/> Benedict Skitarelic, M.D.													
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.													
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/3/67		23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City or Town) Westernport				(County) Md.	
24. FUNERAL DIRECTOR E. Boral				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge					
						DATE MAR 3 1967							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01582

CERTIFICATE OF DEATH

01589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 131 MT. PLEASANT ST.	
3. NAME OF DECEASED (Type or print) MARIA		First G.	Middle QUARTUCCI
4. DATE OF DEATH Month FEBRUARY	Month 15,	Day 1967	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH APRIL 8, 1888	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) CELICO COSENZA, ITALY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GAETANO GRECO		14. MOTHER'S MAIDEN NAME CHIRA MELE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 212-54-8041	17. INFORMANT MRS. LAWRENCE TUMMINO, 131 MT. PLEASANT ST., FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Anemia INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 492X DUE TO Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause (b) Pneumonia 10 days lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I(o) Aneurysm of Ascending Aorta			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 21. I certify that (I) (this hospital) attended the deceased from 2/12, 1967, to 2/15, 1967, that (I) (we) last saw the deceased alive on 2/15, 1967, and that death occurred at 9:05 AM, from causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) CUMBERLAND
20f. (City or town) CUMBERLAND (County) MARYLAND (State)		22b. DATE SIGNED 2/16/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 18, 1967	23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State) CUMBERLAND MARYLAND		23e. REG'D BY REGISTRAR FEB 20 1967	
24. FUNERAL DIRECTOR MARYLOU M. SOWERS HAFER FUNERAL HOME		25b. REGISTRAR'S SIGNATURE John J. Sowens	
VR A15 (4) 20 M 1/68		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01593					CERTIFICATE OF DEATH				
					01590				
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			d. STREET ADDRESS State Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First James	Middle Rankin	Lost	4. DATE OF DEATH	Month February	Month 19	Doy 26	Year 1867
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1874	9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Rankin					14. MOTHER'S MAIDEN NAME Ann Scott				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John Shockey		Address Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Arremia Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Arterosclerosis DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 24 hrs. years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.M. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Moscow (County) A. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 1960 , to Feb. 26, 1967 , that (I) (we) last saw the deceased alive on Feb. 26, 1967 , and that death occurred at 2 A.M. , from causes and on the date stated above.									
22a. SIGNATURE L. R. MILES, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-27-67					
22c. PHYSICIAN'S NAME (Type) L. R. MILES, Jr.		22d. ADDRESS LONA CONING MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/67		23c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery		23d. LOCATION (City or Town) Moscow (County) A. (State) Md.			
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 1967		25b. REGISTRAR'S SIGNATURE George Eichhorn			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01594

CERTIFICATE OF DEATH

01591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6/15/1966 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 30½ Virginia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Williams Last Ronnie Mc Kendrick		4. DATE OF DEATH Feb. 11 Month Day Year 19 67	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/1889 9. AGE (In years last birthday) yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Chargehand		10b. KIND OF BUSINESS OR INDUSTRY at Celanese Corp.	
11. BIRTHPLACE (County & State, or foreign country) Eckhart, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Williams		14. MOTHER'S MAIDEN NAME Catherine Willson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-5432 17. INFORMANT P.O. Box 599, Address Cumberland, Md. Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Arterio Sclerotic cardiovascular disease & hypertension & cerebral apoplexy & left hemiplegia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) & (c) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/15/1966, 19, to 2/11/67, 19, that (I) (we) last saw the deceased alive on 2/11/67 19, and that death occurred at P. M., from causes and on the date stated above.			
22a. SIGNATURE Lee B. Mathews, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 2/13/1967
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE Charles Judge

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01595

CERTIFICATE OF DEATH

01592

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland DOA		c. LENGTH OF STAY IN 1b Mt. Savage d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Riley Albert	Middle Rice	4. DATE OF DEATH Last 2/ 12/ 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired foreman	10b. KIND OF BUSINESS OR INDUSTRY State Road Dept.	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George P. Rice	14. MOTHER'S MAIDEN NAME Sadie Reeser		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 214-07-0303	17. INFORMANT Albert P. Rice, Corrigansville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO Generalized arteriosclerosis (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) 110 Bedford St., Cumberland, Md.	(County) Mt. Savage, Md.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1965 , to Feb. 12, 1967 , that (I) (we) last saw the deceased alive on Feb. 12, 1967 , and that death occurred at 110 Bedford St., Cumberland, Md. from the causes and on the date stated above.			
22a. SIGNATURE James P. Hallinan M. D.			
22b. DATE SIGNED 2-14-67			
22c. PHYSICIAN'S NAME (Type) James P. Hallinan M. D.		22d. ADDRESS 110 Bedford St., Cumberland, Md.	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 16 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01596

CERTIFICATE OF DEATH

01593

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 HOURS 20 MINUTES	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 30 RACE STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIRGINIA	Middle E.	Last SCATURRO
4. DATE OF DEATH	Month FEBRUARY	Day 17,	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-26-1920	9. AGE (In years last birthday) 46	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator	10b. KIND OF BUSINESS OR INDUSTRY Textile	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME SYLVESTER PITTMAN	14. MOTHER'S MAIDEN NAME NORA SHAD		Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT	
		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <i>in Myocardial Infarction</i> stating the underlying cause (c) <i>9 hours</i> last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Jane (County) 8:50 A.M. (State)			
21. I certify that (I) (this hospital) attended the deceased from June , 1967, to Feb. 17, 1967 , that (I) (we) last saw the deceased alive on Feb. 17, 1967 , and that death occurred at 8:50 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7/18/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 19, 1967	23c. NAME OF CEMETERY OR CREMATORIALy Hillcrest Burial Park
23d. LOCATION (City or Town) Cumberland (County) Md. (State) Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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01597

CERTIFICATE OF DEATH

01594

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 415 GREENE STREET			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First IDA	Middle CHRISTINA SCHILLING	Last SCHILLING	4. DATE OF DEATH FEBRUARY 12 1967	Month FEBRUARY	Day 12	Year 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12-20-1877	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEWIS WEBER				14. MOTHER'S MAIDEN NAME Sarah Enos					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arthritis		OUE TO 4425		INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arthritis		(b) DUE TO hypertension		5 years					
		(c) DUE TO Arteriosclerosis cardiovascular disease		20 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pulmonary infarction	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4425		20f. (City or town) (County) (State) 1967			
21. I certify that (I) (this hospital) attended the deceased from 1967 to 2/12/1967 , that (I) (we) last saw the deceased alive on 2/11/1967 , and that death occurred at 1:30 PM from causes and on the date stated above.									
22a. SIGNATURE Almenesman		22b. DATE SIGNED 2/14/67							
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE FEB 17 1967 gCharles Judge			

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1 **H** **M** **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

01598

CERTIFICATE OF DEATH

01595

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 50 yrs.	b. COUNTY allegany	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany Co. Infirmary		d. STREET ADDRESS 30 N. Liberty St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. DATE OF DEATH Month February Day 11 , Year 1967	
3. NAME OF DECEASED (Type or print)	First Edward	Middle Ray	Last Sechler
4. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1889
9. AGE (In years last birthday) 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad	11. BIRTHPLACE (County & State, or foreign country) Paddytown Somerset Co. Pa. U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles H. Sechler	14. MOTHER'S MAIDEN NAME Minnie Otto	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Miss Blanche Sechler Somerset Pa.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Colonie Fistula (b) Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) Ch. degenerativ. ③ arterio sclerosis (c) general ④ artifacts of Specie		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) Kingwood (County) Somerset (State) Penn.	21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stated above.
22c. PHYSICIAN'S NAME (Type) James Stein Inc. Cumb. Md.		22d. ADDRESS	22b. DATE SIGNED FEB 15 1967
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/67	23c. NAME OF CEMETERY OR CREMATORIAL Kingwood I.O.O.F. Cemetery
24. FUNERAL DIRECTOR Lamis Stein Inc. Cumb. Md.		ADDRESS	23d. LOCATION (City or Town) (County) (State) Kingwood Somerset Penna.
		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE James Judge
		DATE FEB 15 1967	

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HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01596

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 51 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS Charlestown St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charlestown Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First O	Middle SHOCKEY	Last SHOCKEY	4. DATE OF DEATH 2/2/1967	Month 2/1967	Day 19	Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 4/10/1915	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Ricker		14. MOTHER'S MAIDEN NAME Myrtle Metz							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHARLES SHOCKEY Lonaconing, MD. (HUSBAND)		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) DUE TO DUE TO DUE TO		CORONARY OCCLUSION		CORONARY SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, MD.		20f. (City or town) (County) (State) Cumberland, MD.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Benedict Skitarelic M.D.		22. DATE SIGNED 2/2/1967			
ACTUAL SIGNATURE Benedict Skitarelic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> X		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> X			
EXAMINER'S NAME (Type) Benedict Skitarelic									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/1967		23c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing MD.			
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR FEB 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01597

01600

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	c. LENGTH OF STAY IN 1b 6 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	d. STREET ADDRESS 61 BROADWAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle HAYES	4. DATE OF DEATH Month FEBRUARY 26, 1967
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. AGE (In years lost birthday) 86 yrs.		B. DATE OF BIRTH MAY 5, 1880	10. IF UNDER 1 YEAR Months 86 Dofs 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.
13. FATHER'S NAME WILLIAM HOPKINS		14. MOTHER'S MAIDEN NAME JANET ANWYEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 213-16-9071	17. INFORMANT MRS. LESTER BRENNEMAN, GUNTER HOTEL	FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arterio-Sclerotic Heart disease INTERVAL BETWEEN ONSET AND DEATH 4200			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) Hypertension (c) Arthritis major joints			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-1-1965 to 2-26-1967 , that (I) (we) last saw the deceased alive on 2-25-1967 , and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE H. C. Diehl		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/27/67
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M.D.		22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND
24. FUNERAL DIRECTOR MARILOU M. SOWERS	ADDRESS HAFER FUNERAL HOME 60 W. MAIN, FROSTBURG	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE Mar 2 1967		DATE Mar 2 1967	

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH				01598			
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Cumberland Years					c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 1200 Bedford Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1200 Bedford Street										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First George	Middle Albert	Last Otto	4. DATE OF DEATH		Month February	Day 23	Year 1967							
5. SEX			6. COLOR OR RACE Male White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH W100WEO <input type="checkbox"/>	9. AGE (In years last birthday) March 9, 1887	79 yrs.	10. IF UNDER 1 YEAR Months 0	Days 0	Hours 0	Min. 0	11. BIRTHPLACE (County & State, or foreign country) Maryland					
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Shoe Store Owner Self Employed			12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Conrad George Smith Amelia Damm			Address Cumberland, Md											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Ruth Elizabeth Smith 1200 Bedford St.			INTERVAL BETWEEN ONSET AND DEATH 1/24/67								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 OUE TO Cerebral Hemorrhage Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO Cidura Crivosa Colon (c) —																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dick's Alley			20f. (City) or town) (County) (State) Cumberland, Md								
21. I certify that (I) (this hospital) attended the deceased from 1/24/67 , 19, to 2/23/67 , 19, that (I) (we) last saw the deceased alive on 2/21/67 , 19, and that death occurred at 7:30 AM , from the causes and on the date stated above.																	
22a. SIGNATURE R. J. Williams			22b. DATE SIGNED 2/24/67														
22c. PHYSICIAN'S NAME (Type) R. J. Williams			22d. ADDRESS 122 S. Centre St., Cumberland, Md														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 26, 1967			23c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md								
24. FUNERAL DIRECTOR John J. Hafer, Jr.			ADDRESS 230 Baltz Ave, Cumberland			25a. REC'D BY REGISTRAR FEB 27 1967			25b. REGISTRAR'S SIGNATURE J. Charles Judge								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

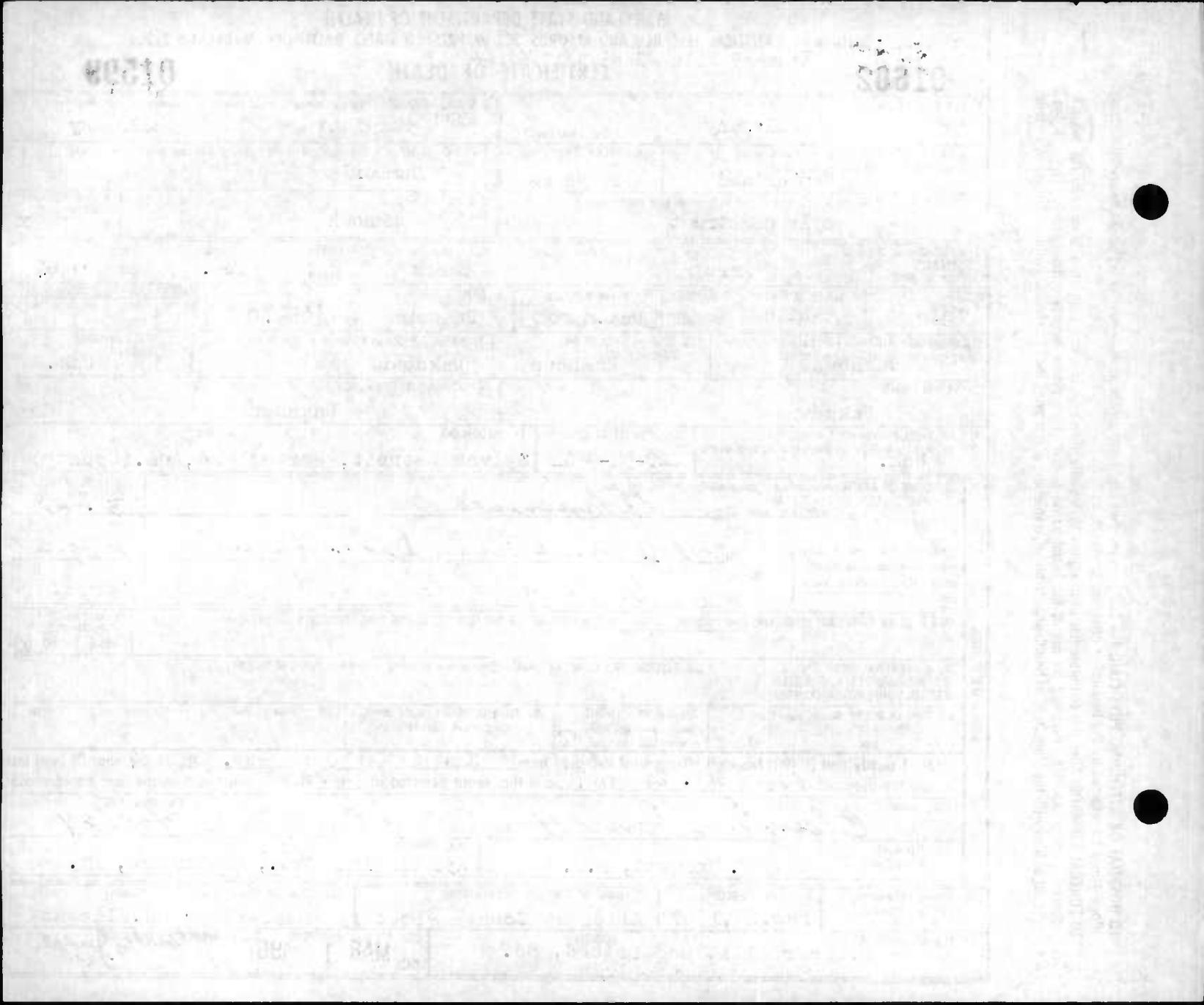
Item #9 Film #G386 3/13/67

01602

CERTIFICATE OF DEATH

01599

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 17 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS Unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin Middle		4. DATE OF DEATH Last Smock Month Feb. Day 24 Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> UNK. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 14/7/80 AGE (In years lost/birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (County & State, or foreign country) Unknown
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 220-52-9961	17. INFORMANT Address Sylvan Retreat, Cumberland, Md. (County)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO <i>Myocarditis - Decompensation</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Arteriosclerosis</i> ONSET AND DEATH (b) (c)		3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 6, 1950, to Feb. 24, 1967, that (I) (we) last saw the deceased alive on Feb. 24, 1967, and that death occurred at 4 P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3/25/67	
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.		22d. ADDRESS 236 Virginia Ave., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Allegany County Cemetery
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS 25a. REC'D BY REGISTRAR MAR 1 1967	25b. REC'D BY CLERK'S SIGNATURE <i>Charles Judge</i>



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																		
CERTIFICATE OF DEATH																		
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Allegany										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 16 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital								d. STREET ADDRESS 465 Warren Street										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
3. NAME OF DECEASED (Type or print)		First Guilio	Middle Nm	Last Squillari	4. DATE OF DEATH	Month 2	Day 11	Year 67										
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/10	9. AGE (In years 56 years birthday) (56) XXX yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef				10b. KIND OF BUSINESS OR INDUSTRY Restauraunt	11. BIRTHPLACE (County & State, or foreign country) Italy, Mornbercelli	12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Eugenio Squillari				14. MOTHER'S MAIDEN NAME Mary Ferrero														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 219-34-6002	17. INFORMANT Sacred Heart	Address Decatur St, Cumberland												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> , to <u>2-11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-11</u> 19 <u>67</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.																		
22a. SIGNATURE <u>L. Michael Glick</u>				22b. DATE SIGNED 2-14-67														
22c. PHYSICIAN'S NAME (Type) <u>L. Michael Glick</u>				22d. ADDRESS 126 N. Smallwood St, Cumberland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery	23d. LOCATION (City, town or county) (State) Cumberland Md. Allegany														
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS	25a. REC'D BY REGISTRAR FEB 15 1967	25b. REGISTRAR'S SIGNATURE <u>Peter J. Scarpelli</u>												
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G386 3/6/67 mh

01604

CERTIFICATE OF DEATH

01601

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 206 MC CULLOUGH ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First GODFREY	Middle D.	Lost	4. DATE OF DEATH FEBRUARY 26	Month	Doy 19	Year 67
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1905	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY W.M.D. R.R.CO.		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME JOHN STOTT	14. MOTHER'S MAIDEN NAME LAURA DAVIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) 4201	16. SOCIAL SECURITY NO. 712-14-1635P	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Heart Disease	INTERVAL BETWEEN ONSET AND DEATH 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and Myocarditis	179
(c) 	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Kennedy Hall Md	20f. (City or town) 1	(County) 	(State)

21. I certify that (I) (this hospital) attended the deceased from 2/25/67 , 19 to 2/26/67 , 19, that (I) (we) last saw the deceased alive on 2/25/67 , 19, and that death occurred at 5:30 A.M. M, from causes and on the date stated above.
--

22a. SIGNATURE R. J. Williams	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/26/67
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS	22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-1-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Ann's Cemetery Wilton Garrett Rd	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Joseph P. Durst Frostburg Md	ADDRESS 	25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE MAR 2 1967		DATE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01605

CERTIFICATE OF DEATH

01602

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 227 CARROLL ST.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH FEBRUARY 24, 1967		Month	Day	Year							
3. NAME OF DECEASED (Type or print)	First ELLA	Middle MAE	Last TAYLOR	5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper - At Home			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME LAFAYETTE MOXLEY				14. MOTHER'S MAIDEN NAME MARGARET SHILLING				Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-03-7977				17. INFORMANT Acute Coronary Occlusion.				INTERVAL BETWEEN ONSET AND DEATH Hours			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 260X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) stating the underlying cause (c)				Diabetic Arteriosclerite Hypertension				Cerebral Vascular Disease.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19 to 1967 , 19, that (I) (we) last saw the deceased alive, on 2/23/67 , and that death occurred at 5:15 AM , from causes and on the date stated above.												22b. DATE SIGNED 2/24/67			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS VIRGINIA AVE.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/67		23c. NAME OF CEMETERY OR CREMATORIAL RoseHill Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland							
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502				ADDRESS				25a. REC'D BY REGISTRAR FEB 28 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01606

CERTIFICATE OF DEATH

01603

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 120 W. OFFUTT ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAVID	Middle T.	Last THARP
4. DATE OF DEATH	Month FEBRUARY	Day 28	Year 1967
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-20-96	9. AGE (In years 71st birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY PLANT NURSERY	
13. FATHER'S NAME HARVEY THARP		14. MOTHER'S MAIDEN NAME ELIZABETH SHAD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217 48 7086	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO myocarditis & Decompensation (c) DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 wks 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 107
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1967, to Mar. 28, 1967, that (I) (we) last saw the deceased alive on Jul. 28, 1967, and that death occurred at M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Clay E. Durrett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/28/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 3, 1967	23c. NAME OF CEMETERY OR CREMATORIAL DAVIS MEMORIAL BURIAL PARK
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE MAR 6 1967
			25b. REGISTRAR'S SIGNATURE j Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01607

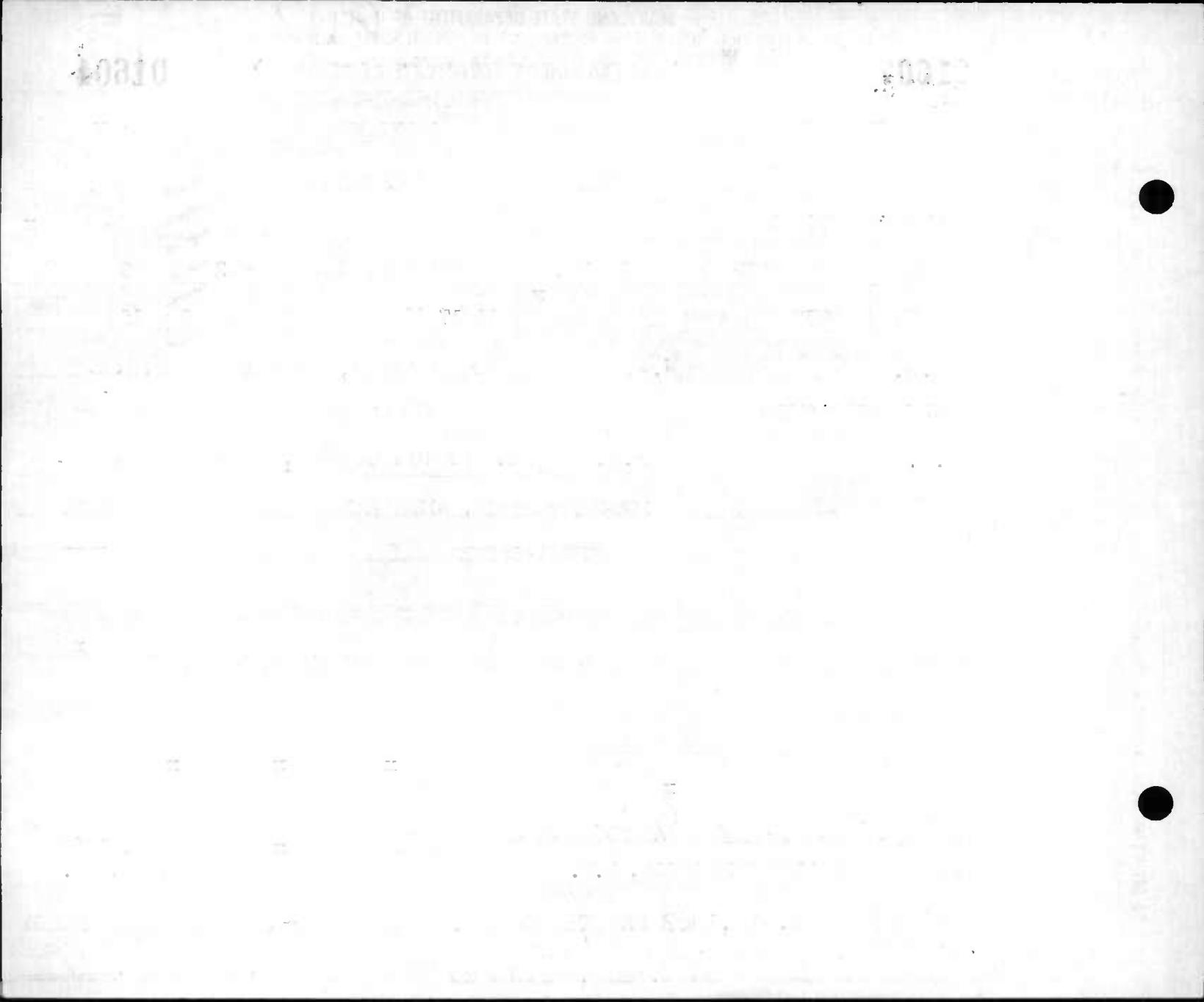
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01604

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH MARION TROUTMAN		First RUTH	Middle MARION
4. DATE OF DEATH 2 9 1967	Month 2	Day 9	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
8. DATE OF BIRTH 11/18/66		9. AGE (In years last birthday) yrs. 2 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.		10b. KIND OF BUSINESS OR INDUSTRY N.A.	
11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAY LEROY TROUTMAN		14. MOTHER'S MAIDEN NAME RUTH/GORDON/ Marion Cecilia Gordon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		16. SOCIAL SECURITY NO. N.A.	
17. INFORMANT MR. GEORGE GORDON, MIDLOTHIAN, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X LOBAR PNEUMONIA, BILATERAL		INTERVAL BETWEEN ONSET AND DEATH DAYS —	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) lost. —		DUE TO STREPTOCOCCUS	
DUE TO —		(c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) —	
(State) —			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		FEBRUARY 9, 1967	
		Address (Street, city, town, or county) CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK
23d. LOCATION (City or Town) FROSTBURG		(County) MARYLAND	
(State) —			
24. FUNERAL DIRECTOR MARILOU M. SOWERS		ADDRESS HAFER FUNERAL HOME	
		25a. RECEIVED BY REGISTRAR FEB 14 1967	
		25b. REGISTRAR'S SIGNATURE <i>Frances Judge</i>	
6-20146-9		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01608

CERTIFICATE OF DEATH

01605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ISABELLE	Middle H.	Last WALKER	4. DATE OF DEATH	Month FEBRUARY Day 8, Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH FEB. 25, 1916	9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME JAMES WALKER			14. MOTHER'S MAIDEN NAME JANET BRIMLOW		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-9803		17. INFORMANT MRS. RUTH LASHBAUGH, FROSTBURG, MD.	Address FROST VILLAGE, FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Coronary Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 sec.</i>					
200X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic CAD.</i> 15 yrs.					
stating the underlying cause (c) <i>Diabetes mellitus</i> 15 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) X			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 X		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	
20f. (City or town) (County) (State) X					
21. I certify that (I) (this hospital) attended the deceased from 1962 , to 1967 , that (I) (we) last saw the deceased alive on 2/8 1967 , and that death occurred at 5747M , from causes and on the date stated above.					
22a. SIGNATURE <i>Martin Rothstein</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/10/67	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, MD.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 11, 1967		23c. NAME OF CEMETERY OR CREMATORIAL PARK FROSTBURG MEMORIAL PARK	
23d. LOCATION (City or Town) (County) (State)				FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS		25a. REC'D. BY REGISTRAR FEB 14 1967	
				25b. REGISTRAR'S SIGNATURE <i>Justice Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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01609

CERTIFICATE OF DEATH

01606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

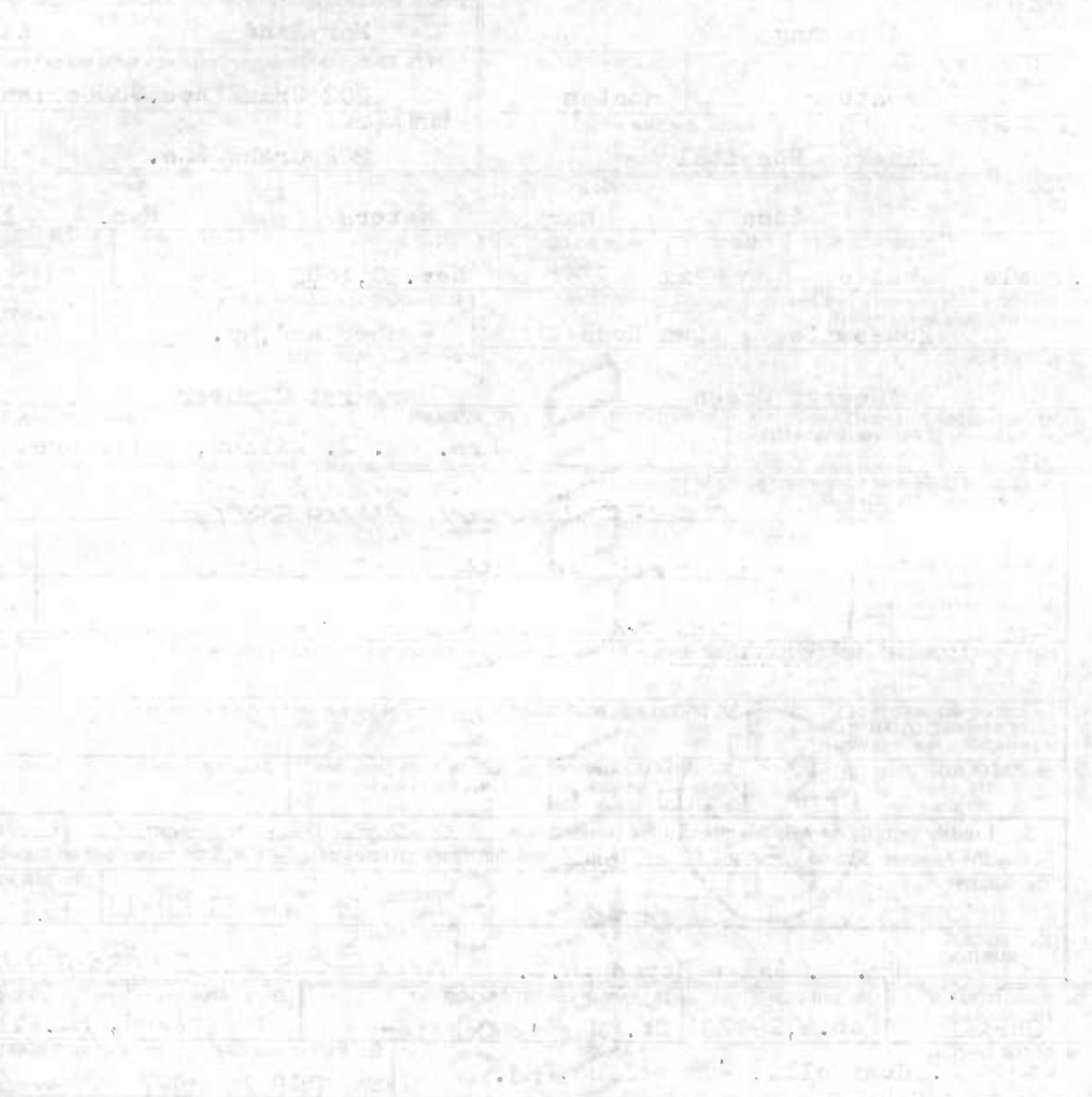
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. STREET ADDRESS 202 Grand Ave. Cumberland	
3. NAME OF DECEASED (Type or print) Anna Mary Waters		First Anna	Middle Mary
4. DATE OF DEATH Feb. 1. 1967	Month Feb.	Doy 1.	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED xx	NEVER MARRIED DIVORCED xx
8. DATE OF BIRTH Nov. 20, 1882	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Margaret Clauser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Wm. T. Dillon, Baltimore, Md.	Address Daughter
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Brain Syndrome DUE TO 447X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Circulatory Disturbance DUE TO (c) Hypertensive Vascular Disease			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1966 , to Feb. 1, 1967 that (I) (we) last saw the deceased alive on FEB 1 1967 , and that death occurred at 9:55 P.M. from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED Feb. 2, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. A. Paige Strong, M.D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 167 E. MAIN ST - FROSTBURG MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR FFB 7 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

40710

STADT WILHELMSBURG

40711



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01610						01607					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 9 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE			d. STREET ADDRESS 01-		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES E WHARTON			First	Middle	Last	4. DATE DF DEATH 2/22/67	Month 2	Day 19	Year 1967		
5. SEX MALE			6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/86	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - DYE HOUSE			10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD WHARTON						14. MOTHER'S MAIDEN NAME ELIZABETH ASHKETTLE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 214-01-0110A			17. INFIRMITY PT'S CHART			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 wk</i>											
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) <i>Atherosclerotic heart Disease</i> 15 yr								
			DUE TO (c) <i>Congestive Heart failure</i> 2 wk								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Atherosclerosis & Osteoarthritis</i>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Xove</i>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Feb. 8, 1967</i>			20f. (City or town) (County) (State) <i>Feb. 22, 1967</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 8, 1967</i> , to <i>Feb. 22, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb. 22, 1967</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>James H. Hallinan MD</i>											
22c. PHYSICIAN'S NAME (Type) DR. HALLINAN			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. DATE SIGNED <i>2-23-67</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2-24-67			23c. NAME OF CEMETERY OR CREMATORIUM ST. PATRICK'S CEMETERY			23d. LOCATION (City, town or county) (State) MT. SAVAGE, MD		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.						ADDRESS					
						25a. REC'D BY REGISTRAR DATE FEB 27 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

01611

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item & Film G385 2/14/67 mh

CERTIFICATE OF DEATH

01608

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing 01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS Beechwood Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		51	Day Year
3. NAME OF DECEASED (Type or print) SIMEON W. WHITEMAN	First	Middle	Last
4. DATE OF DEATH 2/8/1967	Month	Day	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 4/14/1898
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 12	11. IF UNDER 24 HRS. Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired INS. Agent		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Garrett Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Whiteman		14. MOTHER'S MAIDEN NAME Eliza Ellen Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-World War # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Acute myocardial Thrombosis (WIFE) 1/2 hrs ACVD + coronary ar. disease 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from causes and on the date stated above.		22b. DATE SIGNED 2/9/67	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS LONACONING MD
22c. PHYSICIAN'S NAME (Type) L.P. MILES, JR		23d. LOCATION (City or Town) (County) (State) Frostburg, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Memorial Park
24. FUNERAL DIRECTOR GEORGE EICHORN		25a. RECD BY REGISTRAR George Eichhorn 25b. REGISTRAR'S SIGNATURE Judge	
		DATE FEB 10 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01612

CERTIFICATE OF DEATH

01609

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 47 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 744 FAYETTE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1902		9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10b. KIND OF BUSINESS OR INDUSTRY Beverage Saloman			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES P. ZIMMERMAN			14. MOTHER'S MAIDEN NAME LAURA B. KELLY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Squamous Carcinoma, lung, right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Lung Cerebral metastasis stating the underlying cause (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 2 years + 6 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20, 1966, to Feb 25, 1967, that (I) (we) last saw the deceased alive on Feb 24 1967, and their death occurred at 1:05 PM, Ambulances and on the date stated above.								
22a. SIGNATURE Wylie M Faw Jr			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Feb 27, 1967		
22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/67		23c. NAME OF CEMETERY OR CREMATORIAL Hallcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.		
24. FUNERAL DIRECTOR Louis Stein Inc.			ADDRESS 117 Frederick St.			25a. REC'D BY REGISTRAR DATE FEB 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

